Canadian Hospital

- *What Are Our Hospital Bed Needs?*
- *Morden District General Hospital*
- *New Laboratory at Royal Jubilee*

January, 1953

Official Journal—Canadian Hospital Council

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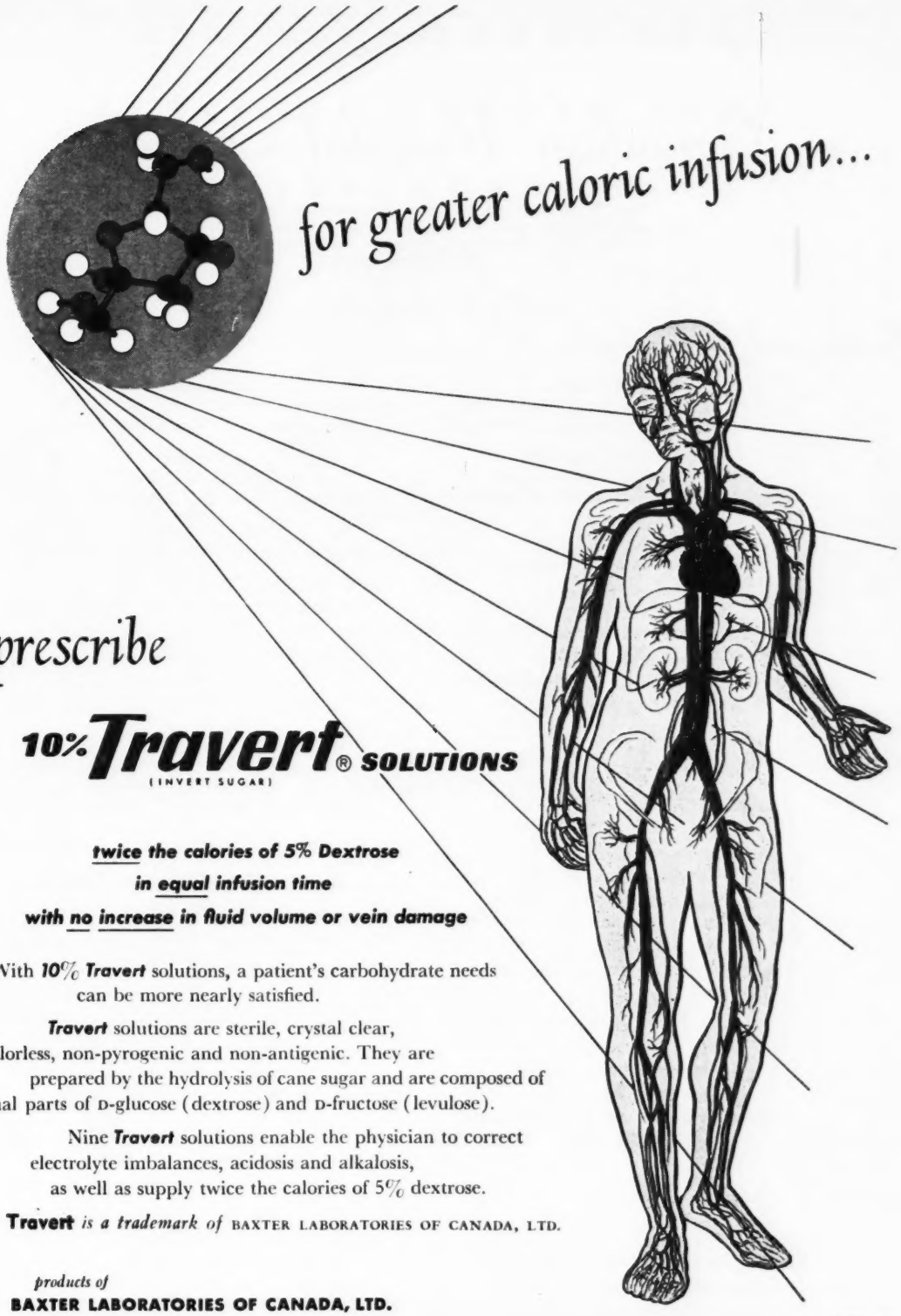

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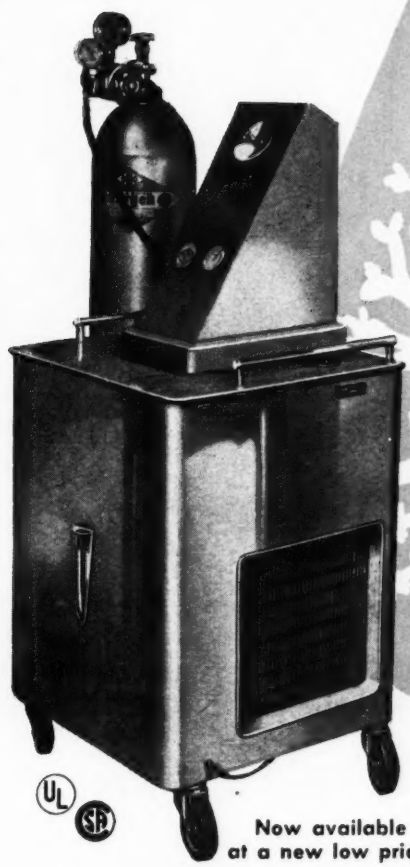

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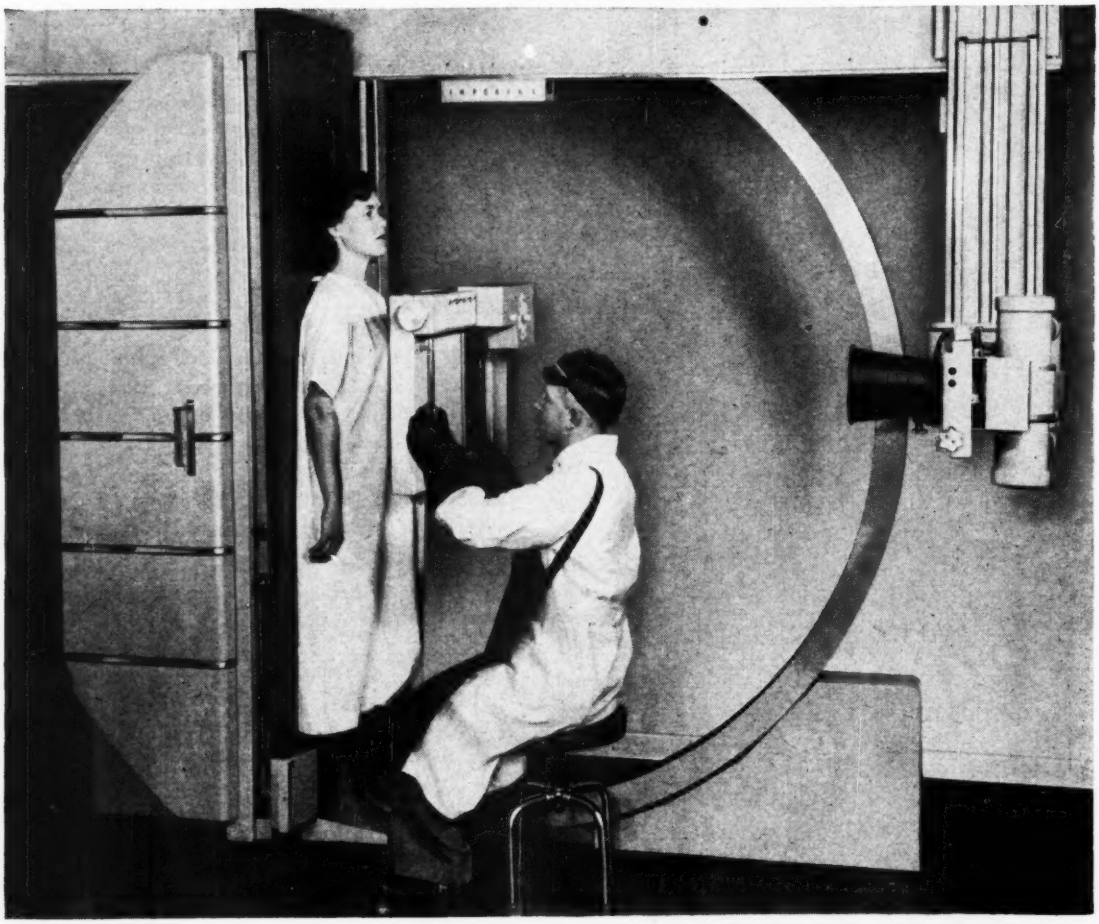

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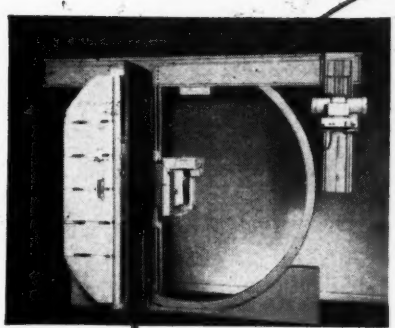

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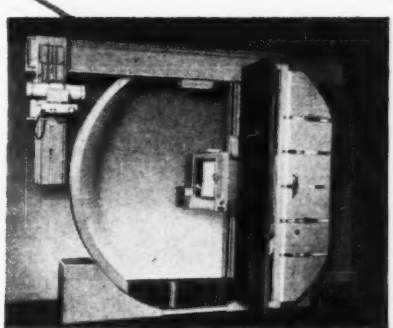

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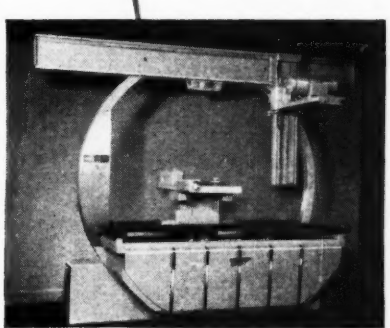
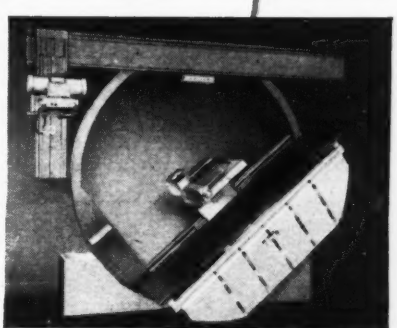


Horizontal



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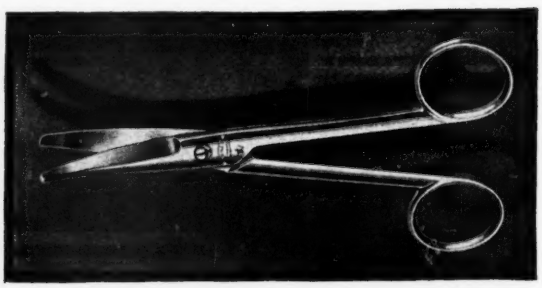

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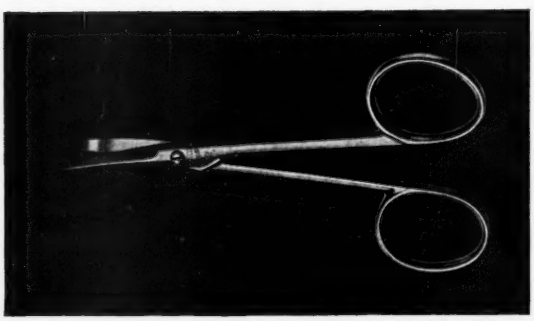

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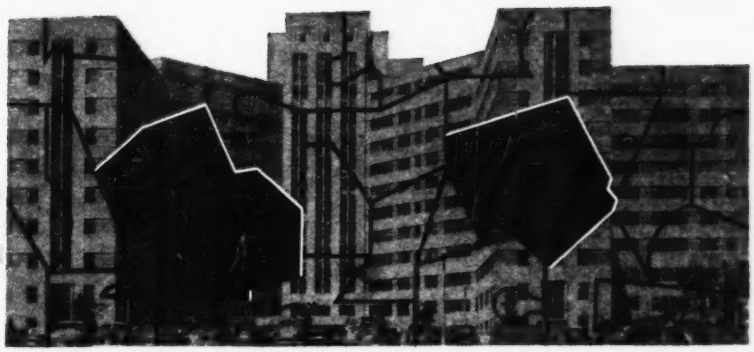

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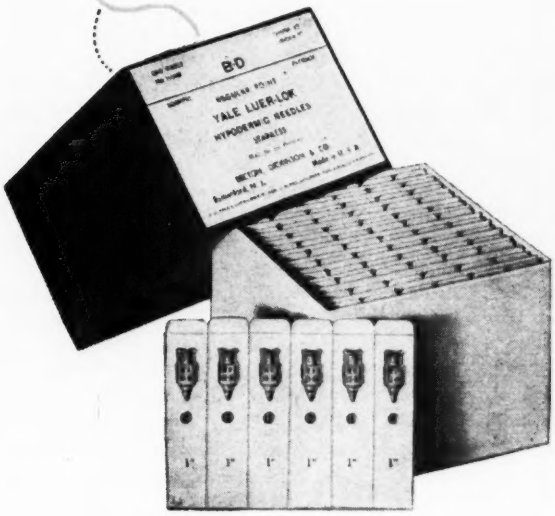

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Notes on Federal Grants

Construction

Three hospitals in Edmonton, Alta., have just been awarded federal grants totalling $669,600 to help meet the cost of enlarging their accommodations. More than $406,600 has been set aside for the University of Alberta Hospital, which is adding space for 375 active treatment beds, an eight-bassinet nursery for premature babies, a six-bassinet isolation nursery, and 18 beds for a psychiatric section. The new construction contains modern obstetrical and paediatric units to replace obsolete services housed in separate buildings. The costs of construction not covered by the federal grant are being met by the province.

The Edmonton General Hospital is to receive $203,000 from both the federal and provincial governments toward the cost of providing space for 180 additional beds and a 69-bassinet nursery. Included in the new construction is a surgical floor with nine operating rooms, new obstetrical and paediatric services, and an out-patient and emergency department.

A grant of $60,000 has been set aside for the Misericordia Hospital to help with the cost of adding 60 more beds through construction of a new wing and re-arrangement of services in the existing building.

At St. Alban's, Nfld., a community health centre has been built in order to bring medical services to approximately 1,850 people in the area. The federal grant will be $3,200, with the remainder of the cost being met by private donations and a provincial grant.

A federal grant of $5,030 has been approved to help meet the cost of enlarging the Notre Dame Bay Memorial Hospital, Twillingate, Nfld., to provide living quarters for the nurses and space for a dental clinic. In addition, about $26,600 has also been earmarked for the hospital to buy technical apparatus, including complete equipment for the new dental clinic. It is hoped later on to develop a dental health service among the school children in this area. Two incubators are to be obtained for the hospital's maternity department. About $15,000 will be used to buy new x-ray equipment so that a well-rounded diagnostic service will be available to the 30,000 people served by this hospital. In addition about $1,000 will be used to buy diathermy equipment for the treatment of crippled children and arthritics.

Mental Health

A neurosurgical service for New Brunswick is to be set up in the Saint John General Hospital, Saint John, with the aid of a federal health grant. Heretofore, New Brunswick has not had a qualified neurosurgeon practising anywhere in the province but the Saint John General Hospital has made arrangements for such a person to come to the city to set up a neurosurgical service. This organization will enable patients requiring surgery of the brain to obtain treatment without travelling long distances outside the province. The federal grant of more than $9,100 will be used entirely to buy the special surgical and technical equipment needed to establish this service.

Federal funds have been earmarked to meet the costs of additional equipment to be used for the treatment of mental illness at the Toronto Psychiatric Hospital in Toronto, Ontario.

The out-patient department of the Toronto Psychiatric Hospital, now located in the old Sick Children's Hospital, is being enlarged to meet the increasing demands on its services. Last year, some 8,000 patients were cared for, with most of them returning for follow-up investigation and treatment. In 1946, the case load was only about 1,500 with few follow-ups. In the same period the staff has grown from eight to nearly 40 full-time workers. More attention is being paid to research into mental health problems; and the out-patient department is becoming an important training centre for psychiatrists, psychologists, psychiatric nurses, and psychiatric social workers. Although the out-patient department of this hospital primarily serves Toronto and district, its services are also utilized by other areas where no mental health facilities exist at present. The federal grant of $17,250 will assist in providing salaries for two additional employees and for equipment needed for the expanding treatment program.

A federal health grant toward the cost of setting up a psychiatric clinic at the Ottawa Civic Hospital has just been approved. The new clinic is to provide full-time facilities for the examination and treatment of patients with mental illnesses in their early stages. This is in line with the current trend of encouraging general hospitals to provide services for the treatment of mental ailments before they reach the stage of requiring prolonged hospitalization.

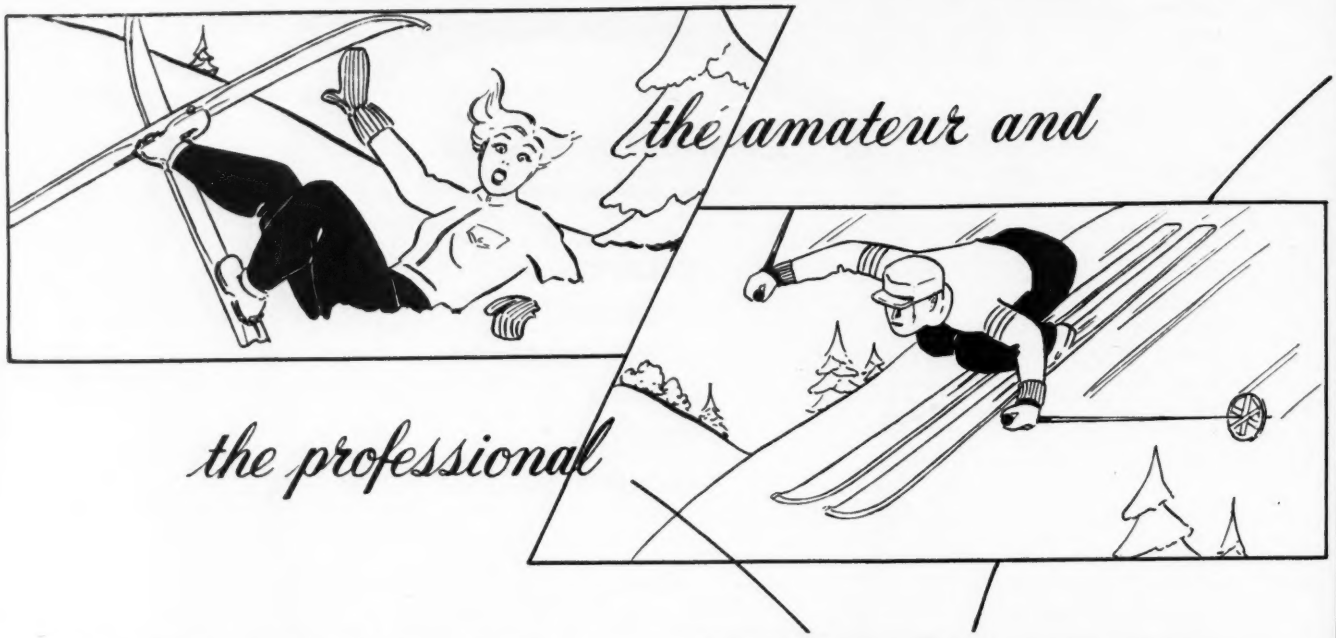
Mental health services in Ottawa were formerly provided by a travelling clinic from the Ontario Hospital, Brockville. This was only a part-time service limited to diagnosis, certification, and advice on the management of cases. Practically no treatment was provided. When the new clinic is fully organized, its professional staff will include a psychiatrist, a psychologist, and a social worker. It is to be operated by the Ontario Hospitals division of the provincial health department. The federal grant of more than $8,400 covers salaries for the remainder of the fiscal year. It is expected that additional funds will be provided later for equipment when it is found from experience just what will be needed.

A new mental health clinic is being set up in Moose Jaw, Sask., with the support of a federal health grant. Until the present time, mental health clinics in Moose Jaw have been held only one day a week, using staff from the Saskatchewan Hospital in Weyburn. Very little therapy could be carried out in the limited time available. At the full-time clinic, treatment will be given to patients referred by doctors and the staff will assist the regional medical health officer in developing a mental health program throughout the community. Special attention will be given to children with serious emotional difficulties.

The province is providing office space and equipment for the new mental health clinic in the regional health centre. The federal grant will be used

(Continued on page 16)

THERE'S A DIFFERENCE BETWEEN



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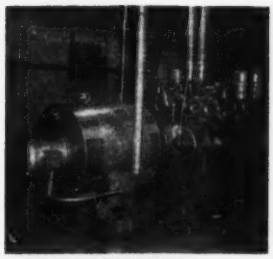

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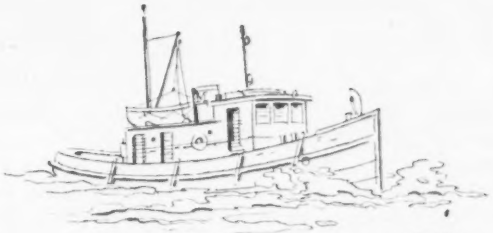

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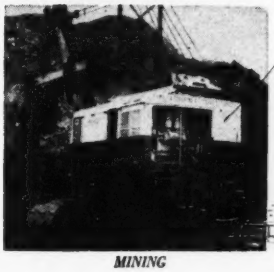

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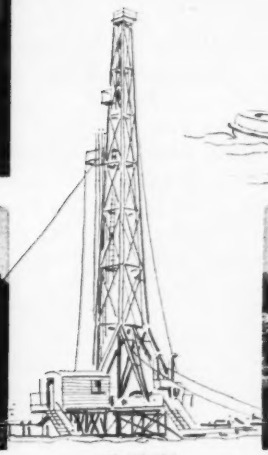

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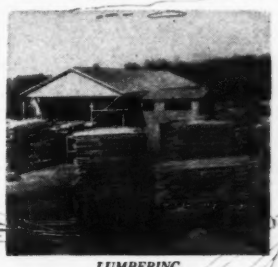

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Federal Grants

(Continued from page 12)

mainly to assist in providing staff. When the clinic is fully staffed, its professional members will include a psychiatrist, a psychologist, and a psychiatric social worker. The service to be set up in Moose Jaw will be similar to that now provided in the MacNeill Clinic, Saskatoon, and the Regina Mental Health Clinic. Cost of the project in the current fiscal year will be about $8,000.

Personnel

Five public health bursaries for post-graduate training have been awarded to British Columbia residents. Two awards for a year's training in psychiatry have been made to two doctors from Vancouver, one of whom is enrolled at the University of Toronto and the other at McGill University, Montreal. On completion of their training, they will return to the provincial mental health service. The assistant medical health officer for the Victoria-Esquimalt Board of Health, has been granted a bursary for a year's study in public health at the University of California. She has been responsible for all school medical services and a major part of the well-baby conferences in her district and will continue her duties in the fields of infant and child health.

Two nurses, both from the staff of the Royal Columbian Hospital, New Westminster, have received bursaries for courses in clinical supervision at the School of Nursing, University of British Columbia.

Public Health

A new type of service to help prevent dental decay among children by applying a solution of sodium fluoride directly to their teeth has been set up in the Weyburn-Estevan section of Saskatchewan with the support of a federal health grant. This program is based on about 10 years' research which has proved that sodium fluoride applied to children's teeth will reduce expected dental decay by about 40 per cent. Sodium fluoride is being used in this way by many dentists and in dental clinics; however, this is the first mobile clinic to be organized anywhere in Canada. The equipment is portable and can be moved from place to place so that service can be provided in small villages and rural areas as well as in the larger urban centres.

The process consists of an initial cleaning of the teeth, followed by a series of four fluoride applications at two to seven-day intervals. The first series of four applications should be repeated at about three-year periods. Ideally, a child should be treated at the ages of three, seven, 10 and 13 years. The first objective of the mobile fluoride unit is to treat all children in the Weyburn-Estevan health region who are three and seven years of age. Later, as trained personnel become available, it is hoped that this service will be extended to other health regions and, eventually, to older children.

The mobile unit is under the supervision of the senior dentist in the health region and is staffed by two specially-trained dental hygienists. During vacation months, the staff is increased to include two senior students in dentistry. Cost of the project, including purchase of equipment, is estimated at more than $9,800 in the current year.

The School for the Deaf and Blind,

(Concluded on page 20)

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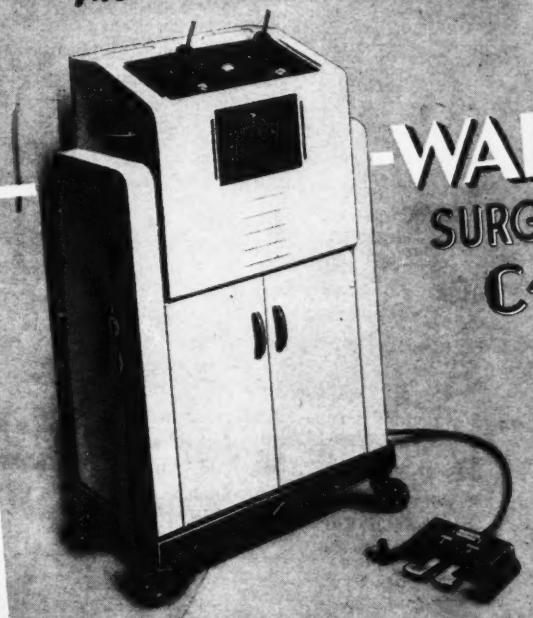

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Federal Grants

(Concluded from page 16)

Vancouver, will receive a grant to assist with the costs of equipping a dental clinic. With the new clinic, students will obtain the same dental service as other Vancouver school children: examination, dental health education, and correction of dental defects. Personnel to operate the clinic are provided by the Metropolitan Health Committee of Greater Vancouver and, when not needed for pupils of the school, will be available for the dental care of other children in that area of the city. The cost of equipment, estimated at $2,900, is shared 50-50 by the provincial department of education and the federal government.

Several hundred dollars have also been earmarked to provide special technical equipment for the 225 patients at the Home for the Aged, Vernon, B.C.

About $17,100 have been earmarked for special surgical equipment for the new neurosurgical operating room at the Toronto General Hospital. This service is available to both in- and out-patients of this hospital and for lobotomies on patients from the Toronto Psychiatric Hospital and the Ontario Hospital, Kingston. At the Ontario Hospital, Cobourg, where about 600 women patients are cared for, approximately $1,370 will be spent on additional equipment for the hospital's laboratory and medical services, to facilitate the proper handling of sick patients and for equipment to be used in recreational therapy.

Expansion of public health services in Owen Sound, Ont., is being supported by a federal health grant. The service is being increased by obtaining two additional public health nurses, a public health veterinarian, and additional clerical assistants. This expansion will enable the local health department to place its facilities at the disposal of larger numbers of people. The nurses will be full-time employees and the public health veterinarian will be employed part-time. The federal grant of about $3,800 for the remainder of the fiscal year covers 60 per cent of the cost of the expanded service.

The Orientation Centre, 39 Gouin Blvd. W., Montreal, has just been awarded a federal health grant to assist it in its child guidance work. The centre's work includes psychological testing and re-education for emotionally disturbed children. It has both a resident care program and a small classroom service provided by the City of Montreal. The federal grant for the remainder of the fiscal year is $7,000. It provides salaries for three psychologists, working full-time, and a medical director-psychiatrist, working part-time.

At the Providence Hospital, Moose Jaw, Sask., laboratory services have been expanded to carry an increasing volume of tests for both in-patients and out-patients and also for specimens referred from other centres. The federal grant toward the cost of enlarging the laboratory is about $3,500.

Life and Learning

I grant you that life is better than learning but even the secondhand experience of reading is valuable and delightful. Just remember that in some mysterious country of the mind, all great writers, artists, scientists, philosophers, are still there waiting for you. All you have to do is to open a book . . . and there they are. — *Will Durant*

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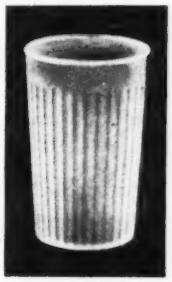

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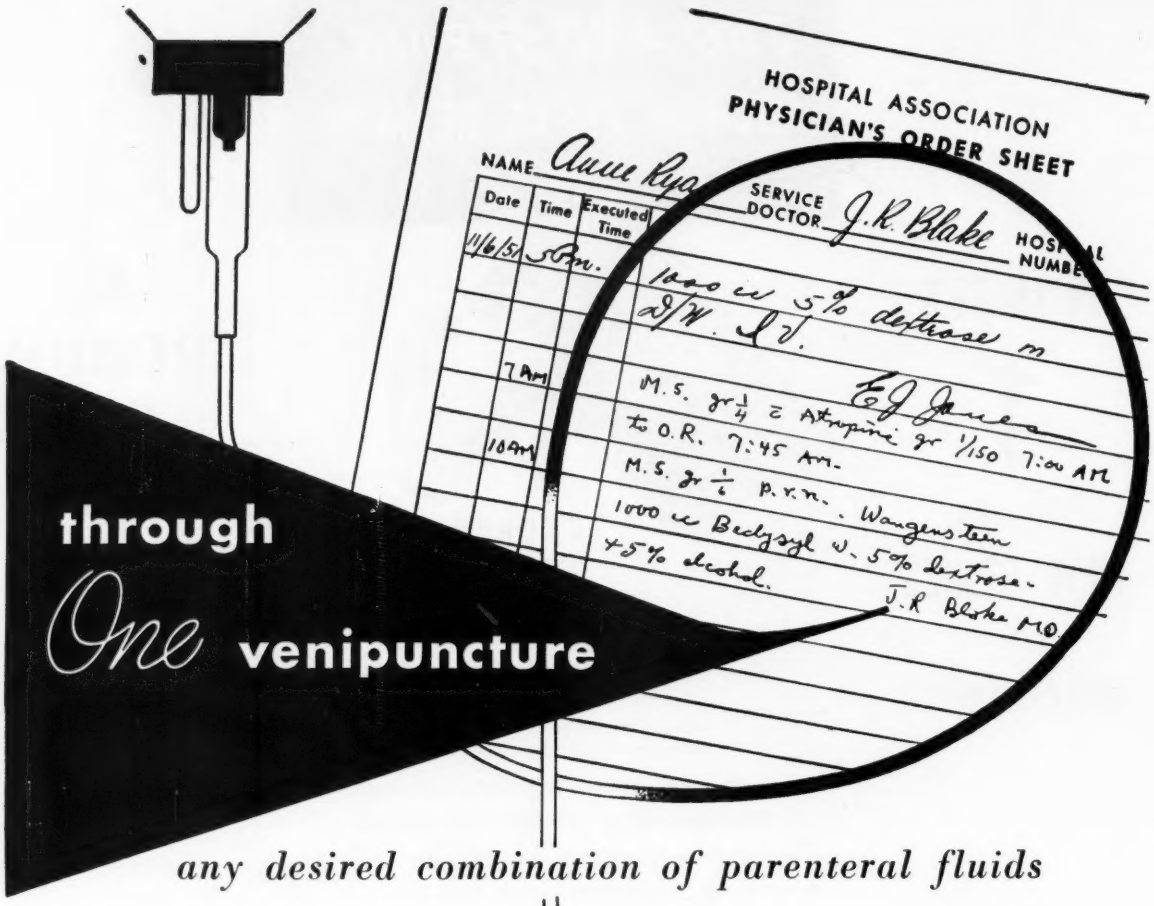

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EXTENSIVE SCALD IN CHILD

27th May. 8.30 p.m. Girl (M.F.) age 3 1/2 scalded with boiling water.

10.05 p.m. Admitted to hospital. Patient had extensive scalds involving 70% body surface—superficial except for areas on back and chest. (Fig. 1) (It transpired that patient had patent ductus arteriosus).

10.45 p.m. Omnopon gr. 1/15 and Scopolamine gr. 1/600 given intramuscularly.

28th May. 12.45 a.m. Plenary Treatment: Penicillin cream 400 units per gram, dressings and crepe bandages applied. Condition good. Haematocrit steady. To continue with copious fluids orally.

30th May. Extensive blistering of trunk, neck, arms and legs. (Fig. 2) Pellicle formation on back. Dressed with Penicillin cream 400 units per gram, massive gauze and cotton-wool dressing, and light Gypsona P.O.P. applied over all crepe bandages.

During the succeeding 3 weeks similar dressings were re-applied at weekly intervals, with Gypsona P.O.P. to prevent patient from interfering with the dressings. (Fig. 3) By 28th June only small areas remained unhealed.

9th July. Split skin grafts from left thigh applied with fibrinogenthrombin glue to raw areas at base of spine and left axilla. Dressed with tulle gras and fixation with Elastoplast.

14th July. 100% take of grafts. (Fig. 4)

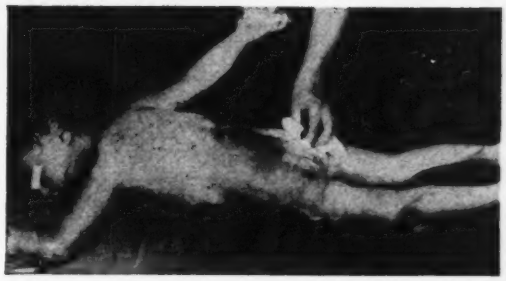
16th July. Walking in Ward.

18th July. Discharged.

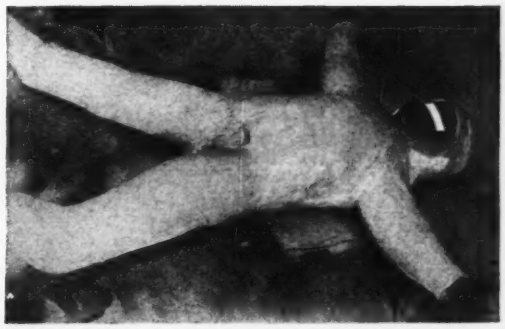
13th October. Recalled after two months in Convalescent Home. Keloid scarring treated successfully with superficial X-Ray therapy.

These details and illustrations are of an actual case. T. F. Smith & Nephew Ltd., of Hull, publish this instance—typical of many—in which their products have been used with success.

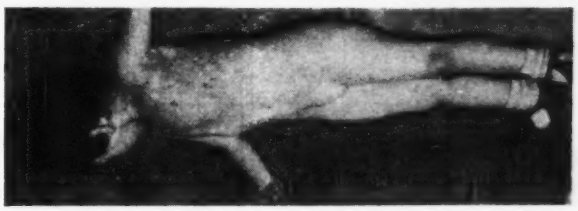
(Fig. 1)



(Fig. 2)



(Above Fig. 3)



(Below Fig. 4)

GYPSONA plaster of Paris Bandages are quick setting and ready for immediate use. They are supplied in widths of 2", 3", 4", 6", 8" x 3 yd. lengths. Gypsona is also available in ready-cut slabs and in rolls of wide material.

JELONET (tulle gras) is an open mesh gauze dressing impregnated with petroleum jelly and 1% Balsam of Peru. It is indicated as a dressing for skin grafts and in the treatment of wounds, burns, etc. Jelonet is sterilized ready for use and is supplied in 8 yd. continuous strips or in tins containing 36 pieces 3 3/4" x 3 3/4".

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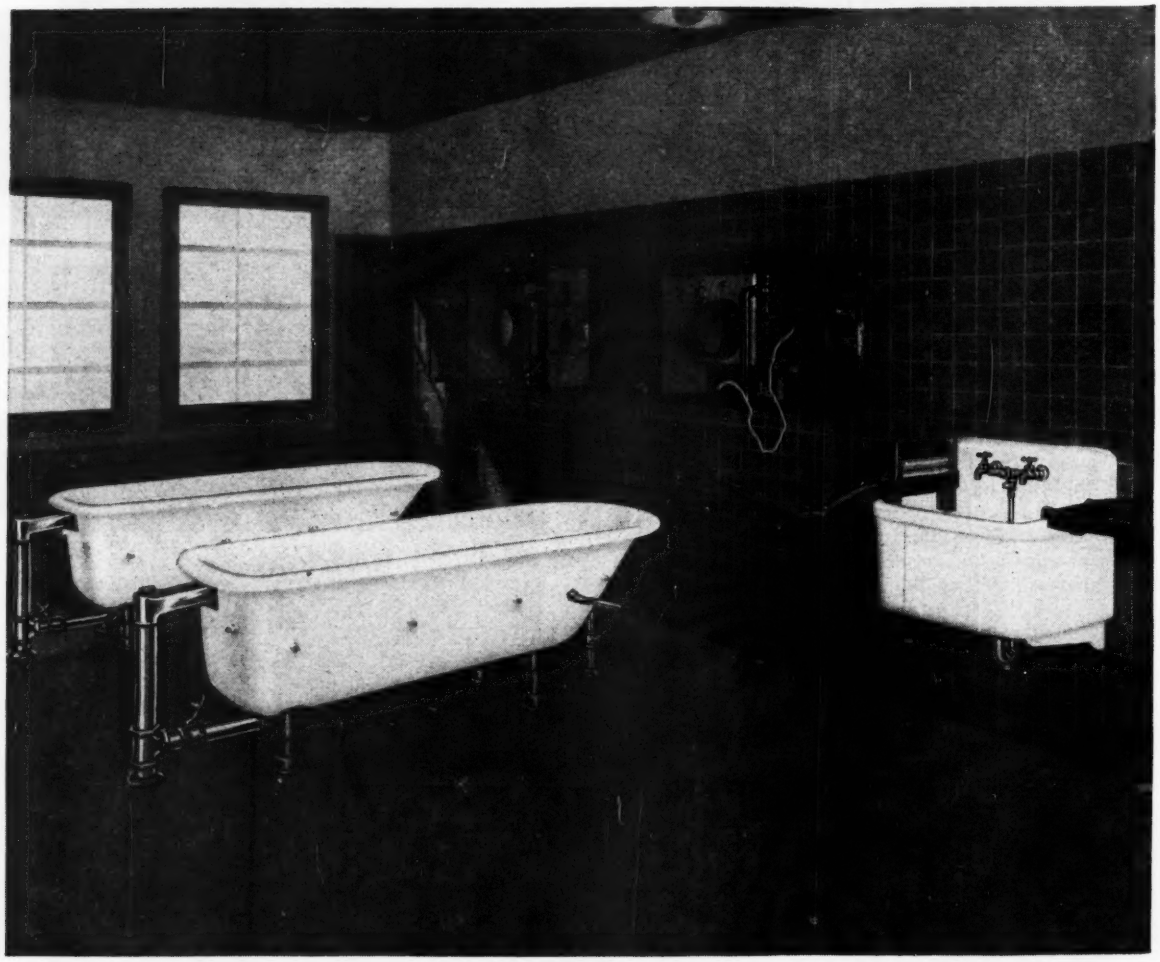

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A. L. Swanson, M.D., Editor

The CANADIAN HOSPITAL

Toronto, January, 1953 Vol. 30 No. 1

Obiter Dicta

For Your Ready Reference — "Canadian Hospital Directory"

COMING as it does with its tradition of positive resolutions, the new year seems to be the appropriate time to announce a new endeavour, one that, it is hoped, will be a real service to Canadian hospitals. With the rapid expansion in the hospital field there has resulted an increasing need and an increasing demand for directive hospital information, concisely assembled, for ready reference by our senior hospital personnel. The compilation of a *Canadian Hospital Directory* is now under way.

Considerable statistical information has been made available to Canadian hospitals in various government publications and in *The Canadian Hospital*, which hitherto has included a list of hospital organizations and allied associations in the January issue and a "Buyers' Directory" in the February issue. Likewise, the American Hospital Association directory number and the Hospital Purchasing File have been of great value. However, there has gradually arisen the need for assembling, under one cover, several types of information that pertain specifically to Canadian hospitals.

Therefore, this directory will contain a geographic and alphabetical listing of our hospitals with the names of department heads; a buyers' directory beamed at purchasing agents; information on hospital and allied associations; and data on approved training programs. It is our earnest wish that the new annual spring publication will give a practical send off to 1953 and to each subsequent year in rendering a real service to Canadian hospitals. Happy New Year!

Canada's Enriched Bread — A Nutritional Insurance

THE sale of enriched white bread and enriched vitamin B white bread became legal in Canada as of January 1st this year. These enriched breads are not being introduced to meet any real nutritional need in our country or in response to any special demand. Authorities on nutrition have assured us again and again that if our citizens would eat a proper variety of readily obtainable foods, in accordance with *Canada's Food Rules*, there is no reason for a vitamin deficiency in this country.

The federal government's decision to make legal the sale of enriched bread is rather in the nature of insurance against any dietary deficiency which might occur. In practice, far too many people do not take time out to eat properly balanced meals — especially at mid-day. Living as we do in a constant rush, a sandwich and coffee (while sitting on a high stool with the next person breathing down your collar) has become all too typical. For those who prefer white bread, enrichment may act as some safeguard against a possible nutritional deficiency.

The government regulations (see page 78) for the control of additions to the "staff of life" are specific and somewhat complicated to the lay mind. They are, however, designed to assure a high standard of product and to prevent abuse by any unscrupulous purveyor. These regulations, coupled with the expressed desire of the National Council of the Baking Industry to offer an improved product, should provide a certain nutritional insurance for us all.

"To Be or Not to Be"

AS developments regarding a Canadian system of hospital accreditation rapidly unfolded in November, 1952, it was deemed wise to insert a special editorial in the December issue which had already gone to press. This was done with all the frantic activity that characterizes any publication and space was found for comment on this very urgent matter. However, time would not then permit a French translation and this omission is now corrected in these columns.

At this moment provincial associations and conferences are individually weighing the pros and cons of a Canadian system — the pros of independence and maturity, as well as the stimulation of our own thought and productivity by the active rather than the passive approach to hospital accreditation. The cons mainly concern the cost and requisite total support of all hospitals if the cost per bed and per hospital is to be borne with relative ease.

Can we find the money? Will the hospitals, each and every one, bear their full share of the load? Here is a challenge to one of the richest nations in the world. Here is a challenge to our hospital unity of purpose. It is not French or English, religious or lay in its nature, but is scientific and professional in its approach. Think well.

Vers de Nouveaux Horizons

AVEC le retrait du programme du Collège américain des Chirurgiens (American College of Surgeons) pour la standardisation des hôpitaux et la formation de la Commission conjointe pour l'Accréditation des Hôpitaux, nous avons vu la fin d'une époque. Il n'y a aucun doute que le programme du Collège americain des Chirurgiens — sous la direction de notre Docteur Malcolm T. MacEachern — a été l'une des plus grandes contributions au monde envers un service d'hôpital amélioré. L'an dernier, la porte s'est fermée sur cette période, et, le 6 décembre, le Collège cédait formellement sa responsabilité au nouveau Comité conjoint, sous la direction du Docteur Edwin L. Crosby. Ainsi, avec la fin d'une époque, une nouvelle époque commence.

Au Canada, nous avons observé ces changements, et, graduellement en sommes venus à réaliser qu'une occasion unique nous a été donnée d'une façon soudaine, quoique modeste. En même temps qu'une porte se ferme, une autre doit s'ouvrir. Alors que le Comité conjoint continuera sans doute dans une tradition semblable — sinon plus élevée — que sous le premier programme, il se peut que nous, Canadiens, pourrons passer le seuil d'une ère nouvelle qui conduit à de plus vastes horizons.

A la réunion biennale du Conseil des Hôpitaux du Canada, en mai 1951, il fut résolu que "le Conseil des Hôpitaux du Canada établira un comité d'étude, lequel examinera et fera un raport détaillé au Conseil des Hôpitaux du Canada, sur le plan le plus practicable et le plus pratique pour développer un programme suffisant de standardisation pour les hôpitaux canadiens." Suivant cette directive, les directeurs du Conseil des Hôpitaux du Canada ont établi un comité sur les Relations d'Associations. Comme partie de leurs fonctions, les membres de ce comité se sont réunis avec des représentants de l'Association Médicale du Canada (Canadian Medical Association) et du Collège Royal des Médecins et Chirurgiens (Can.) pour considérer la possibilité d'établir un programme canadien. Il fut définitivement convenu qu'un programme canadien était, non seulement grandement à désirer, mais tout à fait pratique et possible, pourvu qu'il soit supporté complètement par les membres constituants des groupes participants. La résultat de ces premières réunions fut la formation de la Commission canadienne pour l'Accréditation des Hôpitaux.

Une autre fonction du Comité sur les Relations d'Associations a été de considérer et d'étudier les relations entre l'Association des Hôpitaux américains (American Hospital Association), le Conseil des Hôpitaux du Canada, les associations provinciales et les hôpitaux canadiens. Quoique, à date, aucune recommendation positive n'ait été faite, on a formulé un principe applicable à un programme d'accréditation canadien, c'est-à-dire, que les relations les plus amicales possible doivent être maintenues avec l'Association des Hôpitaux américains, pour le plus grand bienfait de chacun et un plus libre échange d'idées. Loin de nous aucune pensée d'isolement. Au contraire, nous prévoyons une plus grande coopération, tout en établissant et en maintenant notre indépendance, en pensée et en action.

Les hôptaux canadiens sont-ils aussi bons ou meilleurs que ceux d'autres pays? Avons-nous des directeurs et des administrateurs compétents? Bref, avons-nous les connaissances et le talent nécessaires pour établir notre propre système pour l'inspection et l'évaluation de nos hôpitaux? Le Comité canadien pour L'Accréditation est fermement convaincu que nous pouvons répondre à l'affirmative à chacune de ces questions—à une condition. Le succès de notre programme dépendra du ferme appui des hôpitaux canadiens.

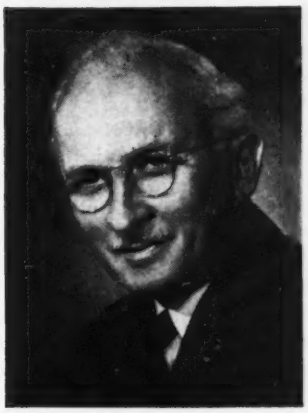
Si nous chérissons notre autonomie et désirons l'indépendance, il nous faut être prêts à offrir un soutien matériel aussi bien que moral. Un tel programme nécessitera un appui financier — un peu de tout le monde, ou une moyenne de six sous par lit si chaque hôpital au Canada fait sa part. Nos médecins ont déjà indiqué qu'ils contribueraient une somme égalant la part des hôpitaux, avec un plus haut pourcentage individuel. Allons-nous emboîter le pas, avec eux, avec les autres grandes nations, avec le progrès?

Afin de déterminer quels sont les désirs des organisations d'hôpitaux constituantes, le Conseil des Hôpitaux du Canada a fait parvenir les renseignements nécessaires à chaque association provinciale, leur demandant de faire connaître leurs intentions aussitôt que possible. Si le mandat est décisif et clair, ce sera alors porte ouverte vers la maturité, dans le mouvement des Hôpitaux du Canada.

Two Dates to Remember: May 12th, the birthday of Florence Nightingale, will again be observed as National Hospital Day by hospitals across Canada. Also, from May 18th to 20th, the 12th biennial meeting of the Canadian Hospital Council will be held at the Chateau Laurier in Ottawa.

What Are Our

Hospital Bed Needs?



Harvey Agnew, M.D.,
Hospital Consultant,
Toronto, Ont.

THE above question is not as readily answered as might be assumed. The answer involves more than the simple application of some formula to the population figures.

For years we have been in a chronic state of never having enough beds. During the past four and one-half years, since construction grants have been available, we have accomplished more in whittling down the shortages than in any previous comparable period; but we are still short in most areas and this will still apply when the initial five-year grant period ends this spring. What is the situation?

During the past few years the various provinces, working under federal health grants, have been studying their provincial health situation, including bed needs. The best available data to date indicates that in 1948, the base line for the national health survey, there were some 53,710 active treatment general and special hospital beds; approximately 6,000 long-stay and convalescent beds; 45,443 mental hospital beds and something over 12,000 beds for tuberculosis.

By March 31, 1953, the end of the five-year period for construction grants, there will be added a net increase of 24,219 active treatment beds, a total of 77,929 beds. An added net 4,819 beds for the chronically ill will make a total in that category of 10,819, or a total for both types, short- and long-stay, of 88,748. That means a net increase in five years of 29,038 — a very creditable performance.

Beds for mental patents have increased by 10,128, making a total by this year of 55,571. Tuberculosis beds have gained a net of 4,076, making a total of 16,076 plus. Total increase over five years: some 45,000 beds and 5,000 bassinets.

If we add 13,423 federal hospitals to this total of 160,395 beds, we obtain a grand total for 1953 of 173,818 beds. Certain discontinued obsolete accommodation not already accounted for should be deducted; but we are informed that this number would not exceed 2,000 beds.

For active treatment and chronically ill cases this works out at about 6 beds per thousand. (The all-over bed ratio is a little over 12 per thousand.) The western provinces have the highest ratio (Saskatchewan has 7.3 per thousand in use, Alberta 6.9, and British Columbia 6.8) and the Maritimes between 5 and 6.

In Ontario the provincial construction grants date from 1947. Active treatment beds will have increased from 14,533 in 1947 to 29,663 by 1953, more than doubling the number. Convalescent beds will have more than doubled, 316 to 684. Beds for the chronically ill also will have more than doubled, 1,643 to 3,756, an increase of 2,113.

Methods of Estimating Need

Over the years various formulae or methods of estimating bed needs have been evolved. These have been helpful but must be applied warily, *cum grano salis*, and cannot be followed blindly. Like many laboratory findings in working out a clinical diagnosis, they must be evaluated in the light of other evidence.

What makes us hesitate to rely too much on formulae is the realization that many hospitals or communities with beds in excess of accepted standards of requirement are still unable to cope with the demand. Conversely, some hospitals, apparently with inadequate beds for the population served, have a surprisingly low average occupancy.

Three methods of estimating need may be mentioned briefly:

1. Bed-Population Ratio

It has been customary to estimate the need as being so many beds per thousand of population. Generally speaking we have talked of 7 to 9 beds per thousand for large cities, with requirements ranging down to 3.5 or 4 for rural areas. The province has recognized as an ideal the general figure 5.5 beds per thousand. The report of the Ontario Health Survey Committee (p. 54) reports 2.2 per thousand for public general hospitals back in 1911 and 4.3 in 1949.

These figures are satisfactory for a whole province or a large area, but mean less when applied to a municipality, and still less when applied to an individual hospital. For instance, Kingston will have 751 beds this year. Greater Kingston has a population of 53,000 (44,000 + 9,000). This works out at 14 beds per thousand for Greater Kingston (or 17 per thousand for the city alone), yet the Kingston area will not have too many beds. Kingston serves a huge area; some 63 per cent of the patients at the Kingston General come from outside the city. Areas getting very little referred work need fewer beds.

An address presented at the Ontario Hospital Association convention, Toronto, Oct., 1952.

The Provincial Survey Committee very wisely did not attempt to use the formula to determine needs in the individual town or hospital, but gave the needs for large areas only (Vol. 1, p. 58). Moreover "The Committee . . . records its conviction that, notwithstanding any area or region 'pattern estimate', before any hospital is built a comprehensive local survey should be done" (p. 59).

2. Bed-Death Ratio

This method has been used in some of the state health surveys in the United States. It is based on the observation that for each hospital death there has been on the average some 250 patient days of care given. This works out at .7 occupied beds (250 ÷ 365) for each hospital death. Given an average stay of 10 days, a hospital death rate of 4 per cent, and a 75 per cent occupancy, at average national (U.S.A.) figures the formula approximates 5 beds per thousand of population, if 50 per cent of all deaths occur in hospital. These conditions may, or may not, apply.

Actually there are so many modifying factors and considerations to be allowed for that its usefulness, except for broad generalizations, becomes quite limited. It is of little value in estimating bed needs for a single hospital.

3. Bed Utilization Method

For estimating the bed needs of an individual hospital, some of us prefer what is called the "bed utilization" method. This is based upon a fact, not a hypothetical figure, the actual average occupancy of the hospital. This is then recalculated as beds required to make this figure represent 80 (or 75) per cent occupancy. Allowance is then made for the immediate increases which almost inevitably follow the opening of a new wing and for a conservatively estimated increase over the next 10 to 15 years, bearing in mind the nature of the community, the competition, the quality of the medical work, and other factors.

With any method much depends upon the ability of the surveyor to appraise and correctly interpret the various local influences which affect the picture and the equally important long-range trends in medical treatment and in hospital practice.

What Beds Do We Really Need?

Much of the foregoing is of concern primarily to the person making the survey, or the board sponsoring it. What is of major concern to those contributing to hospital construction, be they private donors, municipal taxpayers or governments, is "How many beds do we really need?"

It is one thing to estimate the number of beds required to meet the *demand*. It may be quite another thing to work out the number of beds *necessary* to maintain the health care of the community at a satisfactory level.

With our socio-economic legislation and methods of living headed as they are, one wonders if we shall ever be able to keep up with the increasing demand for beds. With more and more of our people covered by hospital insurance, the powerful deterrent of cost to the patient is being rapidly removed. The doctor finds his work and time loss greatly reduced when the patient can be sent to hospital and, naturally, does so if he can get a bed. Few doctors in an area where there is a hospital within reach will book obstetrics except for hospital delivery. In some centres, particularly in certain western cities, a fair number of doctors insist that patients in general either come to the office or, if unable to do so, go to the hospital where the doctor will see them.

Crowded home conditions, the lack of domestic help, and the part-time or full-time employment of the mother in business or industry, may make hospital care practically obligatory. Moreover, the increasing complexity of present-day diagnostic and therapeutic procedures frequently makes hospitalization not only desirable but necessary.

Within my own years of work in the hospital field I have seen our concept of hospital needs go higher and higher. As yet, there seems to be no evidence that the rising index line is levelling off, except in obstetrics where it has practically reached 100 per cent—an exception occurring when the stork outspeeds the taxicab.

The problem is: "How long can this go on?"

If we get compulsory hospital insurance and everybody becomes entitled to hospital care without further charge, the demand will soar still higher, as has been the experience in Saskatchewan and British Columbia.

In the United States it is now proposed to provide free hospitalization for those people coming under the Old Age and Survivors' Insurance arrangements, (*i.e.*, people over 65 and dependents of insured workers who have died). It is estimated that there will be 5,500,000 people aged 65 years and over in 1953. The cost at $15 per diem would be $230,000,000. Where will sufficient beds be found, especially with so many in the old age group and likely to demand extensive hospital care?

Rising Costs

To go on providing more and more beds at present-day costs and with continually rising standards in facilities and equipment demanded is fast becoming a financial impossibility for many communities. Some years ago when hospital costs were around $4,000 per bed for fireproof construction, the writer published an article stating that inflationary tendencies were likely to make costs go as high as $10,000 per bed! He was severely criticized by at least two prominent hospital people for such a ridiculous statement. Now we consider $12,000-$15,000 per bed as normal (it is a fallacious basis to use, of course, and costs can be better expressed in other ways); we consider $16,000-$18,000 as within reason and are accepting $20,000-$23,000 in large teaching hospitals. A few beds and major service changes may make bed costs still higher.

I have said nothing of a second big headache, that of finding nurses and other personnel to staff these augmented facilities. Right now many of our hospitals close down a floor or two each summer "to do a bit of painting and renovating". Is not the compelling reason often the lack of nurses during the holiday season?

It would appear that, in assessing our hospital needs, we must not merely make an estimate of needs by accepted standards but should critically assess these standards by which we estimate the shortages.

In other words, in the light of costs and of the scarcity of skilled staff, we should (a) be sure that we really need the beds we think we do; and (b) endeavour to so plan our construction that it can meet changing hospital requirements over the 75 to 100 years of lifetime which can logically be expected of the present-day steel or reinforced concrete type of construction.

Let us first consider what we need—or do not need.

For one thing we do *not* need certain

"Morning Shadows" by Dr. E. V. Spackman, Lethbridge, Alta.

types of facilities to the extent formerly required. Communicable diseases are being controlled more and more and some, like diphtheria and typhoid fever, are practically unknown in certain communities. The so-called "antibiotic drugs" — penicillin, aureomycin, et cetera—have reduced considerably the length of stay for osteomyelitis, rheumatic fever, erysipelas, and many other diseases, and have almost eradicated mastoid operations. Tuberculosis is on the decline and some provinces are already past their peak demand for sanatorium beds. Venereal diseases have become a negligible item. Pernicious anaemia patients seldom come into hospital for more than a few days at a time.

Also, with earlier ambulation and earlier discharge from hospital, a given number of beds can serve more patients than in former days. With better and more flexible designing than has often been the case, the average daily occupancy can be stepped up, a feature which will give greater revenue and may spell the difference between being in the red and in the black.

It must be borne in mind, however, that a rapid turnover and a high average occupancy increase the proportion of patients requiring intensive care and tax the diagnostic services, the delivery rooms, the operating rooms, the laundry, the nursing staff and, indirectly, the dining rooms, the locker space and other facilities. Earlier discharge is one factor in producing our higher per-diem costs.

Factors Increasing the Need

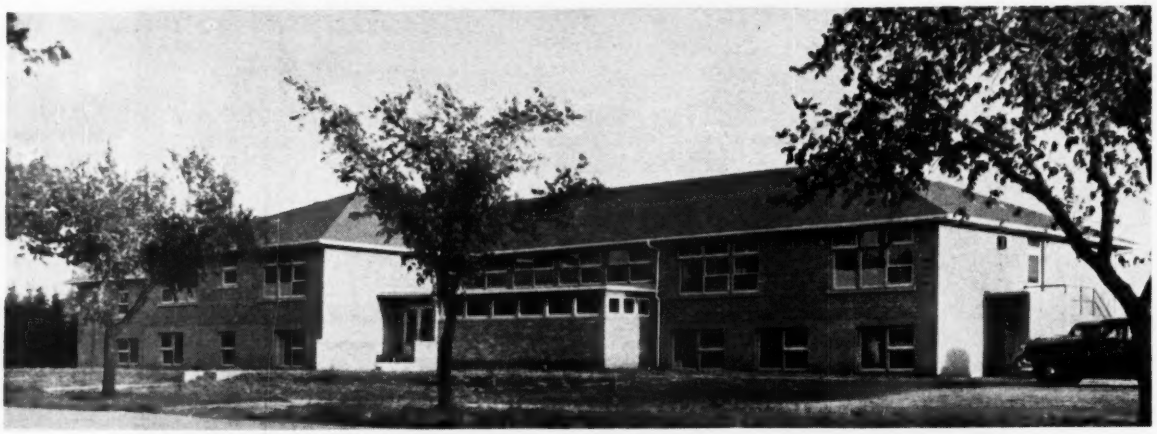
Modern methods of mental care and of mental hygiene have brought this field closer to the general hospital. The active treatment hospital is assuming a broader field of responsibility and many now have psychiatric units caring for both in-patients and out-patients. With the decline in communicable diseases and fewer isolation hospitals, the general hospital may now be asked to provide the isolation facilities for the community.

There is an increasing tendency today to send people to hospital for check-up. The hospital, with its facilities, is the logical place for a complete check-up and the day may soon come when every large centre will have one or more diagnostic clinics in connection with hospitals. But these patients do not need to be admitted so often or, if admission is necessary for certain studies, other tests might well be done before admission, thus shortening the stay. I shall refer to this point shortly.

One questions that we should ask trustees to provide beds so that anyone desiring admission can have a bed immediately, with covers turned back, a hot water bottle already in place and a nurse ready to change the sheets every hour on the hour. I know some demand almost that degree of readiness-to-serve but they are not the ones who put up the money to provide those beds. There should be enough beds that emergency or urgent cases can always be looked after. This would apply also to obstetrics, for the stork is a determined fellow when he gets airborne. One does not like to see suspected cancer patients kept waiting. But there are quite a few operative and medical cases where a delay of a few days does not endanger life. We must be reasonable in assessing the need.

The point is that it would require a serious raising of charges if enough beds were provided to meet peak demands at all times, for that would mean empty beds at other times. Charges can only be kept to an equitable level by keeping the hospital fairly full at all times and by planning

(Continued on page 70)



New Modern District General Hospital

Carries on Early Traditions

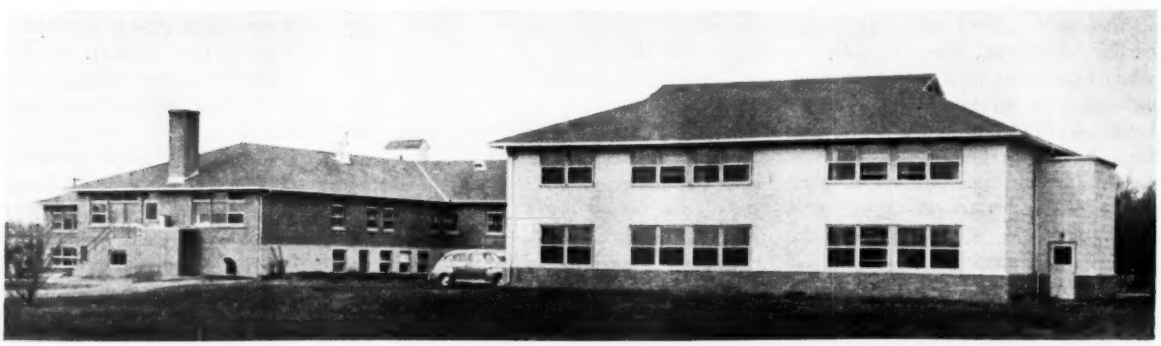
Judge J. Milton George, Q.C.,
Chairman,
Morden Hospital Board,
Morden, Man.

H. H. G. Moody,
Moody and Moore, Architects,
Winnipeg, Man.

JUST SIXTY YEARS ago, the first hospital was established in Morden under the auspices of the Masonic Lodge and was financed by donations from various lodges. It was named Freemasons Hospital and incorporated by a special act of the Legislature of Manitoba. To meet the demands made upon it, a new wing was added in 1928.

For thirty years it was the only hospital in southern Manitoba and served patients for that whole area, until a hospital was built at Deloraine in 1922 to serve the western part of southern Manitoba. During all the years of its existence, Freemasons Hospital had been liberally supported by the citizens of the area it served. It has stood as a monument to those early pioneers whose very existence depended upon helping one another and who recognized good health as the foundation of success and happiness for their fellowmen. Service and self-help was their motto. The operation of Freemasons Hospital for the past sixty years is ample proof of how sincere they were and how well they lived up to that motto. New generations caught the torch that was thrown to them by their forefathers and carried on the work so well begun. Today residents and former residents of Morden district can look back with pride on the example that has been set by Freemasons Hospital in the field of hospital service in Western Canada.

In more recent years, it became increasingly apparent that a new and larger hospital was necessary to meet the growing demands of the area. With the passing of the Health Service Act by the Manitoba Legislature in 1945 and its provisions whereby new hospitals might be built by the issue of municipal debentures as a means of financing construction, an opportunity was presented of securing for Morden



This rear view of the hospital shows (left) the wing for long-term patients, and the nurses' residence to the right.

district a new hospital and nurses' residence. In addition, health grants were made available by the provincial and federal governments to assist with the cost of construction. Thereupon a new hospital district was formed, including the west half of the municipality of Stanley, all of the municipality of Pembina, parts of the municipalities of Louise and Thompson, the town of Morden, and the villages of Manitou and Pilot Mound. It is known as Morden Hospital District No. 21. The scheme for the formation of this hospital district, approved by the ratepayers of the area, included the construction of six-bed medical nursing units at Manitou and Pilot Mound, as well as a new nurses' residence and general hospital at Morden, the latter to contain 34 active treatment beds, 22 beds for the chronically ill, and 12 bassinets.

The units at Manitou and Pilot Mound have been constructed and have been in operation for over a year. The district hospital and nurses' residence were formally opened on July 3, 1952, as a special feature of the Old Timers' Reunion held in Morden on July 3, 4, and 5. Nothing could have been more fitting on such an occasion as it marked the 60th anniversary of the first hospital in Morden and the opening of the new institution which could carry on the established tradition.

The Chronically Ill

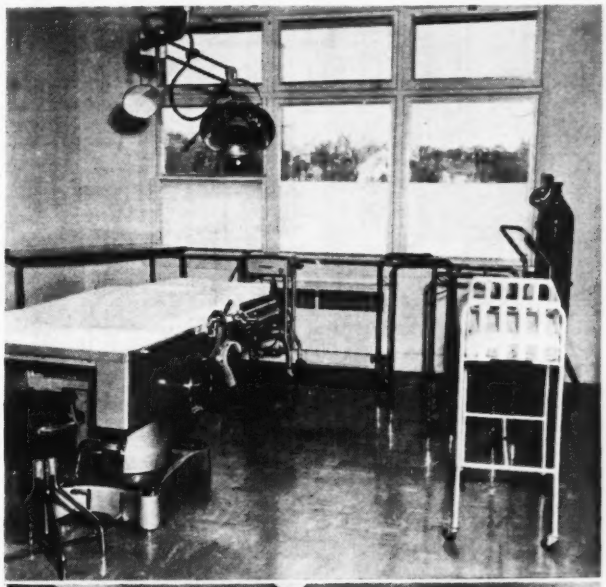
Occupying a well-chosen site, adjacent to the lovely grounds of the Dominion Experimental Farm, the new Morden District General Hospital provides services not available in the Freemasons Hospital. A whole wing with 22 beds has been designed for the care of the chronically ill and is operated in conjunction with the rest of the hospital. There are no institutions in rural Manitoba solely for the care of the chronically ill. The responsibility for this care rests upon general hospitals with the result that many beds needed for acutely ill persons have been occupied by long-stay, chronically-ill patients. A great, if not the greatest, need in Manitoba today is to provide for the care of those who do not require specialized nursing and medical care but who are unable to care for themselves and depend upon a limited amount of nursing. The Morden hospital is attempting to fill that need and is the first hospital in the province to give such a service in conjunction with general hospital service.

Every department of the Morden District General Hospital has modern equipment, including a 200 M.A. x-ray machine. More complete laboratory facilities are under the charge of a qualified x-ray and laboratory technician who will provide a service not heretofore available. There is comfortable accommodation for the domestic staff in the hospital proper and for the nursing staff in the new residence. Good recreational facilities are provided in both the residence and the hospital.

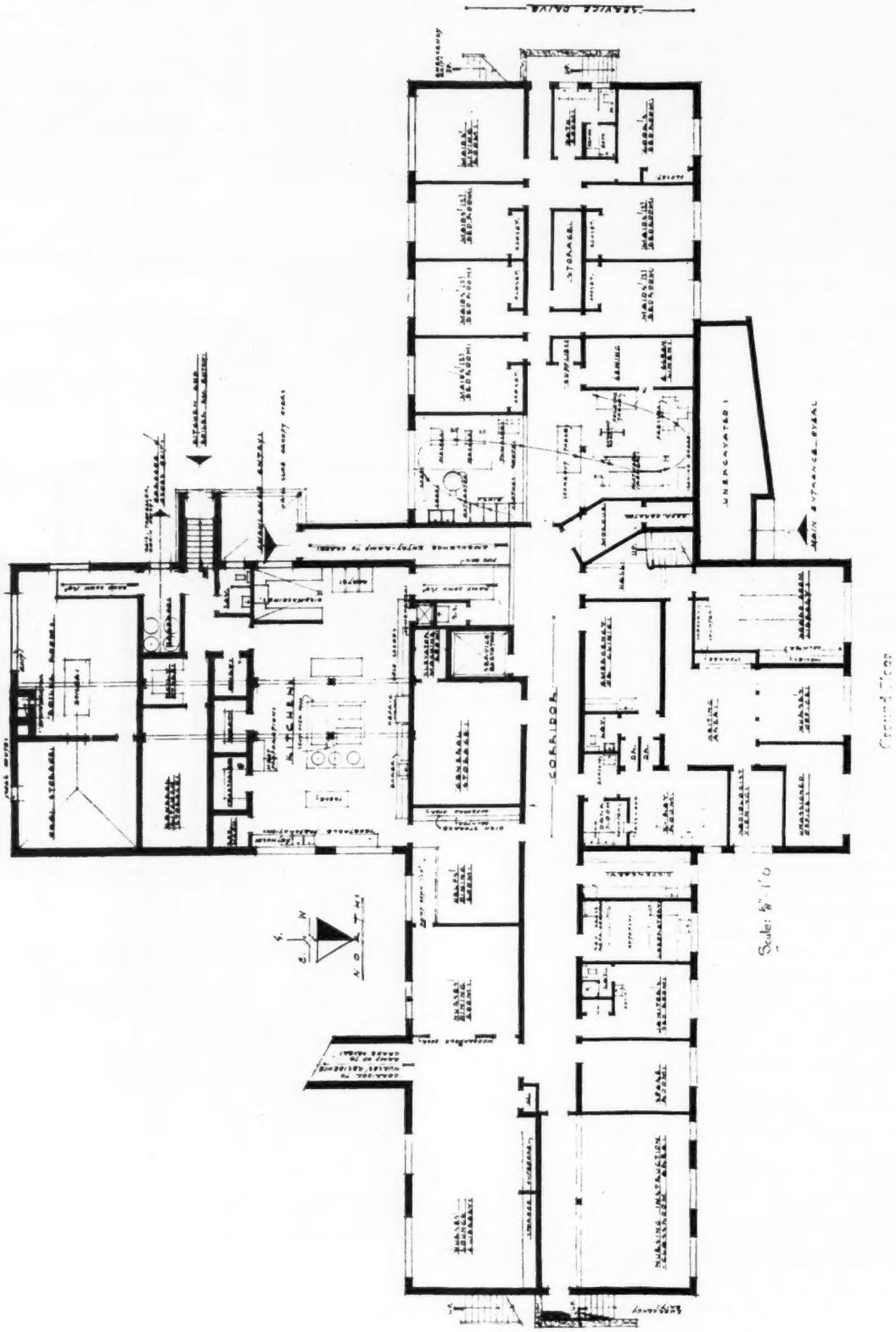
Construction Notes

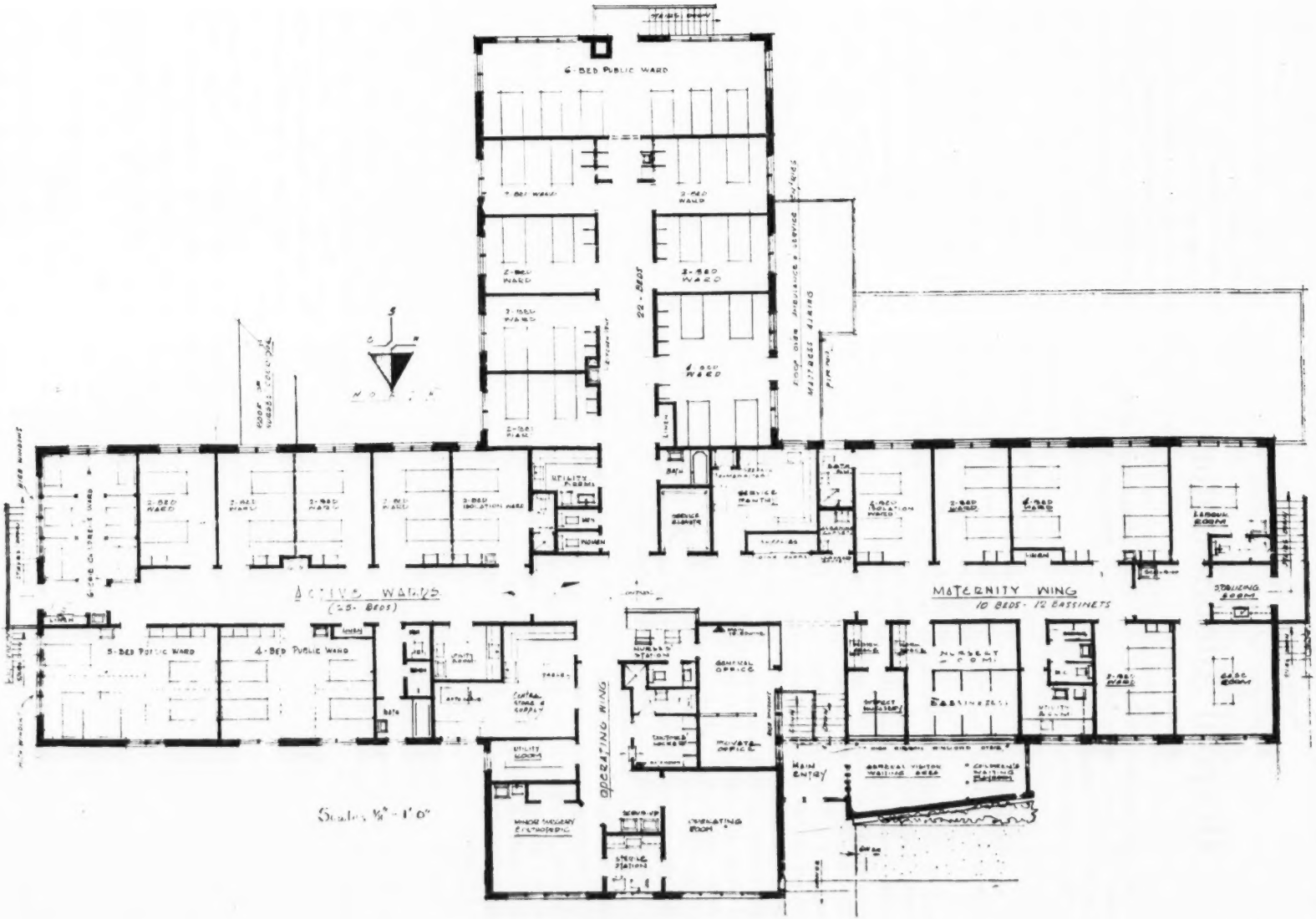
Two storeys in height, the new hospital has a lower storey of concrete wall construction with concrete subfloors for both ground and first floor. The concrete walls are insulated with cork and plastered inside. Floor fin-

(Floor plans next page, Text concluded on page 88)



Above: a glimpse of the case room; below, the corridor to the left of the nurses' station opens into the operating room theatre and the main hall leads into the section for acute cases.


CORRIDOR
KITCHEN
UNEXCAVATED
Ground Floor


6-BED PUBLIC WARD
2-BED WARD
4-BED WARD
22 - BEDS
ACTIVE WARDS
(25 BEDS)
MATERNITY WING
10 BEDS - 12 BASSINETS
5-BED PUBLIC WARD
4-BED PUBLIC WARD
OPERATING WING
GENERAL OFFICE
PRIVATE OFFICE
OPERATING ROOM
MAIN ENTRY
NURSERY
BASSINETS
Scale: ⅛" = 1'-0"

First Floor

A Medical Practitioner Speaks to Hospital Administrators

J. C. Moscovitch, M.D.,
Vancouver, B.C.

TO serve the patient efficiently, economically, and humanely, is your hope and desire as administrators. This requires perfect co-operation between the hospital administration and the doctor. They must work together as a balanced team. So let us analyze how we can achieve this Utopia.

Historically, hospitals were originally lodging places for the sick and dying. Medicine was associated with witchcraft, religion, and the barbering trade. The general public was ignorant and uneducated because education was restricted and limited. Science was in its infancy. For many centuries we note the growth to be slow, with comparative expansion interdependent and interlocked. As science advanced rapidly, especially in the past century, the community structure changed — people congregated in large centres. Industries expanded and became mechanized. Transportation left the ground and took to the air. Communication became a matter of seconds. Medicine stepped out of its empirical treatment stage to become an exacting science. Surgery performed never-dreamt-of miracles. Research provided drugs and chemicals to treat sickness and disability at a rapidly increasing rate. Now, as the public became better educated, the human requirements came to the fore and more consideration for the sick was demanded. People began to realize that in helping their neighbour cross the road, they themselves crossed. Through pressure on various levels of government, they insisted upon adequate facilities to meet the need. This must always match and keep pace with the advances in medicine and science. With the ever changing tempo in our social thinking, our increasing taxes added to the inflationary flux, we find hospitals leaving the philanthropic field to become big businesses needing trained administrators.

With this brief and sketchy background let us consider a few of the problems that face the administration in an average sized general hospital. Never lose sight of the fact that institutions are not all alike nor have they similar problems. One must, therefore, individualize. You must become familiar with your own situation. You must take stock and list your assets and liabilities.

The Doctor

The most universal complaint one hears is: "Doctor so and so thinks he is King Tut. He pays no attention to rules or regulations. He feels he can ride roughshod over everybody. Who is this so and so?" He is an individual who has spent a lifetime obtaining an education and training. He accumulates experience through years of internship to give him the privilege and sufficient confidence to go into the world and treat the ailments of humans. He is imbued with a spirit which is best expressed in the oath and prayer of Maimonides of the 12th century:

"Thy Eternal Providence has appointed me to watch over the life and health of Thy creatures. May the love for my art actuate me at all times; may neither avarice, nor miserliness, nor the thirst for glory, nor for a great reputation engage my mind; for the enemies of Truth and Philanthropy could easily deceive me and make me forgetful of my lofty aim of doing good to Thy children.

"May I never see in the patient anything but a fellow creature in pain.

"Grant me strength, time, and opportunity always to correct what I have acquired, always to extend its domain; for knowledge is immense and the spirit of man can extend infinitely to enrich itself daily with new requirements. Today he can discover his errors of yesterday and tomorrow he may obtain a new light on what he thinks himself sure of today.

"O God, Thou hast appointed me to watch over the life and death of Thy creatures; here I am ready for my vocation."

The Patient

Who is the patient who seeks hospitality and assistance within your walls? The patient can be male or female, youth or adult, pauper or millionaire, literate or illiterate, agreeable or disagreeable, conscious or unconscious; as a general rule requiring your institution to assist in regaining health or for relief of pain or rectifying disability. From personal experience of nearly 25 years I can say that the average individual does not wish to go into hospital until it is necessary. Whether this is caused by the heritage of fear — dislike of separation — economic or social reasons, it is not my intention or purpose to dwell upon. While visiting a rather ill patient one day, the wife happened to mention that her feeling about a doctor, when she was a child, could best be illustrated by a little poem she had composed. It read as follows:

Patient's Lament

What does he want to see my tongue for,
Feel my pulse and tap my chest about,
What right has he to ask me where the pain is,
Don't I pay him just to find that out?
Why hadn't he ought to know if he's a doctor,
Of course he had, then why be so absurd,
If I say I'm ill, I'm ill, ain't I,
Can't you take my word?

Innumerable common complaints can be listed. Here are but a few:

1. Doctor so and so sends his patients into the hospital who do not actually need to occupy a hospital bed.

2. Doctor so and so always keeps his patients in the hospital a much longer time than is generally necessary.

3. Doctor so and so is most careless about the histories, progress notes, diagnoses of his patients or of completing his records satisfactorily.

4. Doctor so and so is most unreasonable in his attitude toward hospital employees.

5. Doctor so and so is always asking for special favours.

6. Doctor so and so's patients never come to be admitted at a reasonable

An address presented at the Western Canada Institute for Hospital Administrators and Trustees, Vancouver, June, 1952.

hour, et cetera, et cetera.

What is the solution? That is the $64 dollar question. That is really what you want to know.

Rules and Regulations

Any business, and a hospital today is big business, must have rules and regulations — or chaos. All rules and regulations fall into one of two divisions: (a) straight administrative ones and (b) medical administrative ones. It, therefore, behooves you to organize a medical staff, medical committee, or a group of medical advisors. To this group you should present as a courtesy in logical order, in simple language, the various administrative rules and regulations that come under division A. You should get their opinion, their agreement, and their support for these. You should then place before them the problems that fall into division B, *i.e.*, the medical administrative ones, and assist them by guiding them to formulate adequate coverage. Once that has been accomplished you should see that both groups receive adequate publicity and that this publicity goes out at frequent intervals to refresh the minds of all concerned. Any contravention of division A, which you have proved to yourself, should be dealt with in an impartial manner after a reasonable "cooling off period" is allowed. Any contravention falling into division B should be passed on to your medical staff to be dealt with. They should, in turn, report to you the results of their deliberations and action taken.

In your thinking and action do not attempt to mould individuals to a rule but rather see to it that there is sufficient elasticity to mould the rule to the human being. One must remember that too much rigidity is just as bad as too much elasticity. Fairness, firmness, and impartiality are the pillars of success in administration. Here are some gems for the administrator: always be certain of your facts; never pay attention to gossip; do not spread gossip; do not play politics; do not become embroiled in arguments outside your institution or take sides, thus avoiding unnecessary antagonism; be tactful; be humble; be impartial; be the liaison officer; and utilize all your community resources in your interest.

If at all feasible try to rotate the medical advisory staff among as many practitioners in your community as

(Concluded on page 80)

An Educational Opportunity

THE ENTRY into a new year is an event which brings to most of us a degree of satisfaction for work accomplished as well as regret for those things we might have done better. Coupled with this is the spirit of optimism and adventure which prompts us to seize each opportunity which may be presented.

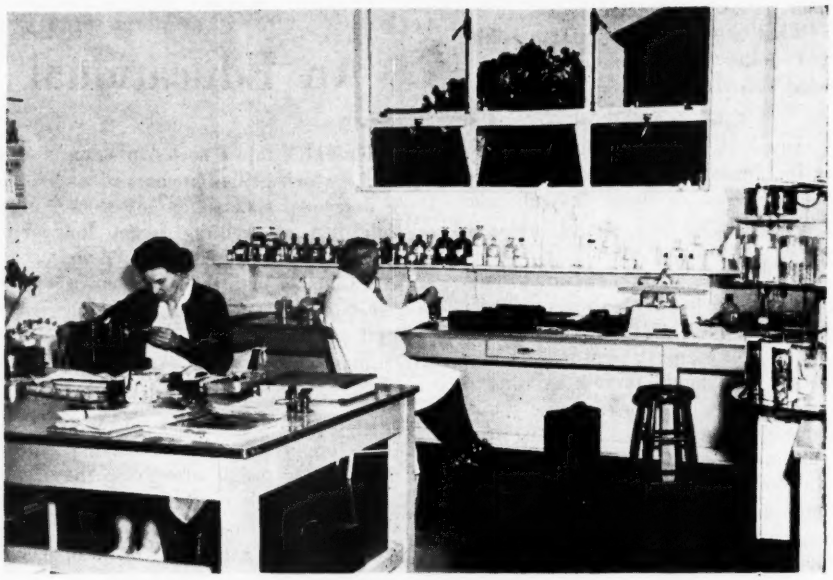
The extension course in hospital organization and management provides an opportunity for educational advancement to people already in the hospital field. This course, sponsored by the Canadian Hospital Council in co-operation with the Department of Hospital Administration, University of Toronto, and supported generously by the W. K. Kellogg Foundation, has been commended by both students and leading hospital authorities. Just over a year ago, the first students (including hospital administrators, nurses, doctors, and other administrative personnel) from hospitals of all types, located in every province of Canada, were submitting their first assignments. At the same time, working parties were being organized throughout Canada to select and prepare the basic information that would be included in subsequent lessons; and qualified personnel were being recruited among hospital administrators to mark the assignments submitted by the students. Likewise, the initial plans for the first summer sessions, which were subsequently held at Queen's University and Regina College, were beginning to take form.

For the purpose of preparing and reviewing the 28 lessons in the course, the support of specialists was enlisted through several national associations and advice was received from individual authorities working singly or in groups. At the present time, approximately 100 interested persons, all of whom are experienced in the hospital field, are assisting either directly or indirectly in these tasks, as well as assisting the full-time staff in marking some thousand assignment papers. With the commencement of a second academic term in September, 1952, a new class of first-year students was enrolled and the original students commenced their second year of study. Total enrolment now stands at 95.

The course consists of two academic winter sessions of home study based on prepared lesson material, each year being completed by attendance at a summer session for lectures, seminars, and field trips. This year there will be a combined summer session for all second-year students at Macdonald College, Ste. Anne de Bellevue, Quebec. First-year students from eastern Canada will also meet at Macdonald College but in a separate section, while first-year students from western Canada will meet at the University of Alberta, Edmonton. The committee on education of the Canadian Hospital Council has thoroughly explored the problems involved in arranging summer sessions and the decision to hold only one session for second-year students was based on two main considerations: (a) the problem of procuring an experienced, well-qualified faculty; and (b) the problem of affording all students an opportunity to broaden their knowledge by studying hospital problems outside their local areas.

The demand for the extension course has far exceeded the number of students deemed advisable, with the result that it has been necessary to request many applicants to defer their enrolment. Those individuals, in the category just mentioned, who wish to be considered again this year should be sure to request that their names be transferred to the 1953 list. Others wishing to apply for the first time should write to the Secretary, Committee on Education, Canadian Hospital Council, 280 Bloor St. West., Toronto 5, for application forms and information about the course. The closing date upon which applications will be accepted for the next class is March 31, 1953. However, it is suggested that applications should be submitted well in advance of that date if at all possible.—*D. MacI.*

New Laboratory at Royal Jubilee Hospital

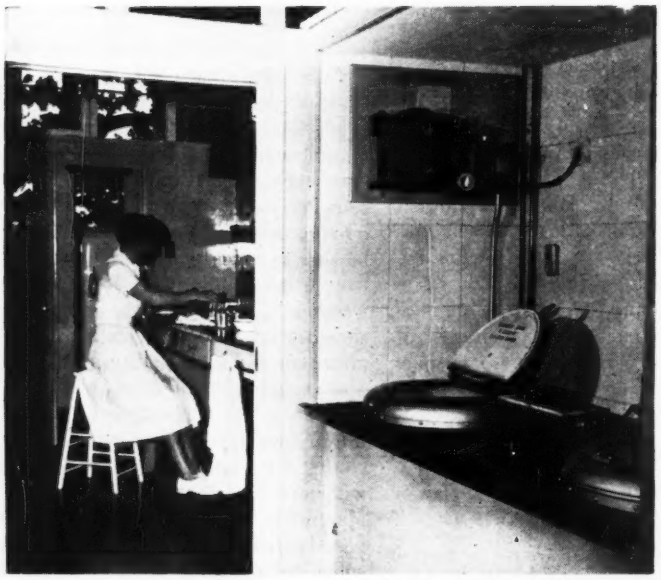


The spacious and well lighted histology unit.

Co-operation in Planning

Michael A. M. Fraser,
Administrative Assistant,
Royal Jubilee Hospital,
Victoria, B.C.

THE J. Keith Wilson Memorial Laboratory, a new addition to the Royal Jubilee Hospital in Victoria, B.C., was officially opened in March, 1952. This modern, conveniently laid out and economically constructed building is indicative of what can be accomplished through the medium of co-operative planning. The many unique features which were incorporated into its construction were largely initiated by Dr. R. G. D. McNeely, chief pathologist, and his staff. Members of the hospital's excellent maintenance department, who completed the cabinet work, equipment installations, and other details of the internal construction, are responsible for the subsequent materialization of his ideas and those of the planning body as a whole. The design of this laboratory is a tribute to the ingenuity of the group.



The centrifuge booth with the glassed-in serology unit in background.

This structure was, in a sense, planned from the inside out — *i.e.*, the area and design of the individual laboratory units were first determined. These were then fashioned to scale in the form of cardboard cut-outs. The cut-outs, in turn, were juggled about until the planners were satisfied that they had achieved the most feasible arrangement, due consideration being given throughout to the establishment of an efficient work flow. Henry Whittaker, M.R.A.I.C., the architect engaged on this project, successfully interpreted and reproduced the ideas presented.

The Royal Jubilee Hospital, like other hospitals throughout the continent, has been feeling the pressure of an ever-increasing volume of work

occasioned by the insistent demands of the parent communities for more and more accommodation and services. The construction of the 6,500-square-foot laboratory is one of the steps being taken by the board of directors of this hospital in meeting these demands.

The original laboratory facilities proved to be inadequate to handle the more than 135,000 examinations per year. Consequently, the department was forced to spread into adjacent patient areas. This, however, was merely an instance of "robbing Peter to pay Paul". The opening of the new laboratory made possible the release of these rooms which subsequently were used to accommodate 22 much needed ward beds.

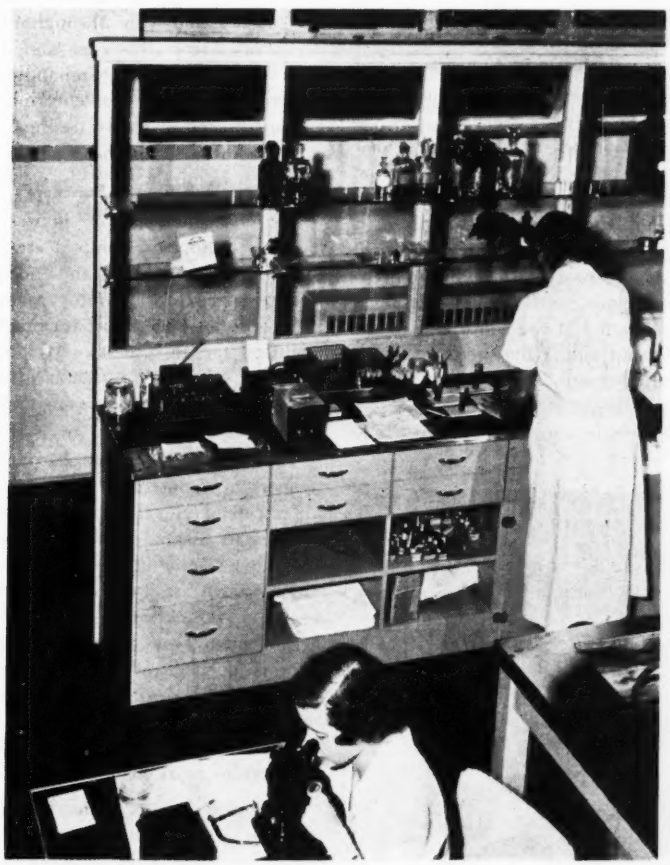
Since the hospital directors were not prepared to embark on a large scale building program at this time, it was incumbent upon the planners to decide on a location for this laboratory in keeping with plans for a possible hospital expansion program in the future. Its present site, adjacent to the laundry plant, is the outcome of such planning. The location is such that, if required, the building could quite readily accommodate an expansion of the existing laundry facilities. Apart from being located outside the main building, it is as convenient and accessible to the bulk of the patient areas as possible.

Construction

The new building is constructed of concrete blocks between reinforced concrete columns. It is faced with yellow brick to conform with the exterior architecture of the main hospital buildings. Wilson joists support a concrete slab roof. These specially fabricated steel joists were utilized in order to provide a main floor area entirely free from supporting pillars or partitions. This space is subdivided into a series of compartments by means of 7-foot stub frame partitions. The centre, or dividing partition, is designed to accommodate the power, water, and gas supply lines serving these areas. These lines, in turn, are carried along the basement ceiling and for ease of maintenance have been left exposed. Stub partitions were adopted to ensure a maximum of natural lighting and free circulation of air, as well as to effect an economical and flexible installation—flexible to the extent that it permits a future redistribution of any section of the department or the utilization of the entire space for another purpose at a minimum of expense. The ceiling has been covered with acoustic tile and the floors with battleship linoleum. Experience has demonstrated that where stub partitioning is used in a working area of this size, it is almost mandatory that such steps be taken toward soundproofing it.

Corridors adjacent to the outside walls and surrounding the centrally constructed laboratory compartments made possible the installation of large windows, thus providing adequate natural lighting without sacrificing wall space in the individual sections themselves. Artificial lighting is provided through the medium of banks of semi-direct fluorescent fixtures. These installations run the width of the ceiling and are spaced at 10-foot intervals, the length of the building. They produce an illumination of 45-foot candles at counter top level.

In an attempt to reduce interference, cross traffic, and a great many unnecessary steps and subsequent fatigue on the part of the technicians, the various compartments have been set up as self-contained units, *i.e.*, in so far as the routine testing procedures are concerned. Glass washing and volume centrifuging are still largely centralized activities.



Extensive use of glass, and stub partitions, is well illustrated in this picture of the haemotology unit. Note convenient arrangement of microscope desks and staining counter.

Self-contained Units

The urinalysis, Tbc. sputum, serology, and bacteriology units, using the greater percentage of the glass-ware, are located in the immediate vicinity of the wash-up section. The washing of glassware has been greatly facilitated through the installation of a mechanical washer in this area. Sterilizing equipment, including a 20" x 36" autoclave and a 220-volt forced circulation dry air sterilizer, is located between the wash-up and the bacteriology sections to accommodate the routine sterilizing of all contaminated utensils before they are handled by the glass

washer.

A centrifuge booth housing two large capacity centrifuges is positioned between the urinalysis and Tbc. sputum unit and the serology unit. Most of the centrifuging handled by this equipment is related to the tests performed in these sections. The booth itself is lined with acoustic tile and the floor of the booth, on which the centrifuges are mounted, is essentially a floating platform mounted on a series of felt cushions. It is a most successful installation in that the centrifuges operate very quietly and vibrations from the booth are negligible.

The serology unit is glassed in up to the ceiling in order to maintain a higher temperature in the area during the time the Kahn tests are being completed. The glassed portion is fitted with black drapes which may be drawn when Kahn tests are read.

A combination reference library and reading room is located between the serology and bacteriology units. This room is used and appreciated by student technicians and staff alike.

Haemotology

The haemotology unit features a special installation in the form of a staining counter fitted with a centrally positioned stainless steel trough running the length of the counter. Equipment shelves are built at a convenient height above this trough. Two microscope desks, adjusted to suit the technicians concerned, are positioned on both sides of this counter. These desks are purposely placed facing the plain green-tinted side walls of the unit to reduce possible eye strain. Each is equipped with a swivel chair in order that the technicians may stain their blood films and use their microscopes while remaining seated. The desks, themselves, are positioned at a convenient distance from the walls in order to facilitate the movement of the staff about the unit, with a minimum of interference to those members who may be completing a cell count or are otherwise engaged.

Biochemistry

An area of approximately 475 square feet has been devoted to the biochemistry section. Sufficient counter space permits the equipment required for each major test to be set up permanently. Provision has also been made for the storage of a limited quantity of supplies for these procedures, in the immediate area concerned.

For the sake of convenience and the fact that the volume of glassware used here is not significant, the washing-up is completed within the section itself. To aid in this operation and to ensure a ready supply of dry utensils, the equipment includes three drying cabinets. These are simply glass-doored cupboards fitted with suitable racks to retain the various articles of glassware used. A home type electric fan heater is installed in one side of the cabinet and the heated air is vented through an opening in the opposite side.

In addition, this section is provided with two built-in transite-lined fume cabinets. The fumes are mechanically exhausted from the cabinets and vented through independent transite-lined ducts to the roof of the laboratory.

A spacious, well-lighted histology unit is located at the south end of the building adjoining the tissue specimen examining room. This latter area is well ventilated and conveniently laid out to include a gross specimen examining counter and storage room, as well as a combination microscopic examining bench and slide filing cabinet.

Offices

Completing the facilities on the main floor are modern offices and a reception room. Four booths, two of which are equipped with couches, have been built adjoining the waiting area to accommodate out-patients. The office is connected to each of the laboratory units by means of an office intercommunication system. Each of these units is also fitted with a telephone jack so that during after-office hours the technician on duty can take the office telephone to whichever work area is most convenient at the time.

Common to all the laboratory units are the open counters which have been fitted with interchangeable under-counter drawer and cabinet fixtures. These fixtures increase the flexibility of the over-all work area and permit the re-arrangement of an individual unit if, at any time, it is found advantageous to do so. Wheeled tables are also used extensively throughout the laboratory for convenience and to reduce to a minimum the rehandling of equipment and the problems inherent in the transfer of glassware, et cetera, from one area to another.

Research Area in Basement

The basement floor houses the morgue, autopsy room, a research room, a dark room, and adequate storage space for laboratory supplies. Provision has been made for employee facilities on this floor. At present, the chief engineer's office is also located here, as it is most convenient to the power plant.

The autopsy and research rooms are temperature controlled. Heated fresh air is forced into these rooms through anemostats located in the ceiling over the autopsy table and work areas. The air, in turn, is exhausted from the room at floor level. This particular arrangement was introduced for the express purpose of providing a continuous down draft in the vicinity of the work areas in order to carry odours, et cetera, down and away from the persons working there.

Provision has been made for two autopsy tables in this room. An eight-foot, four-tube cold cathode fixture providing an illumination of 100-foot

(Concluded on page 80)

Photographs, courtesy B.C. Travel Bureau.

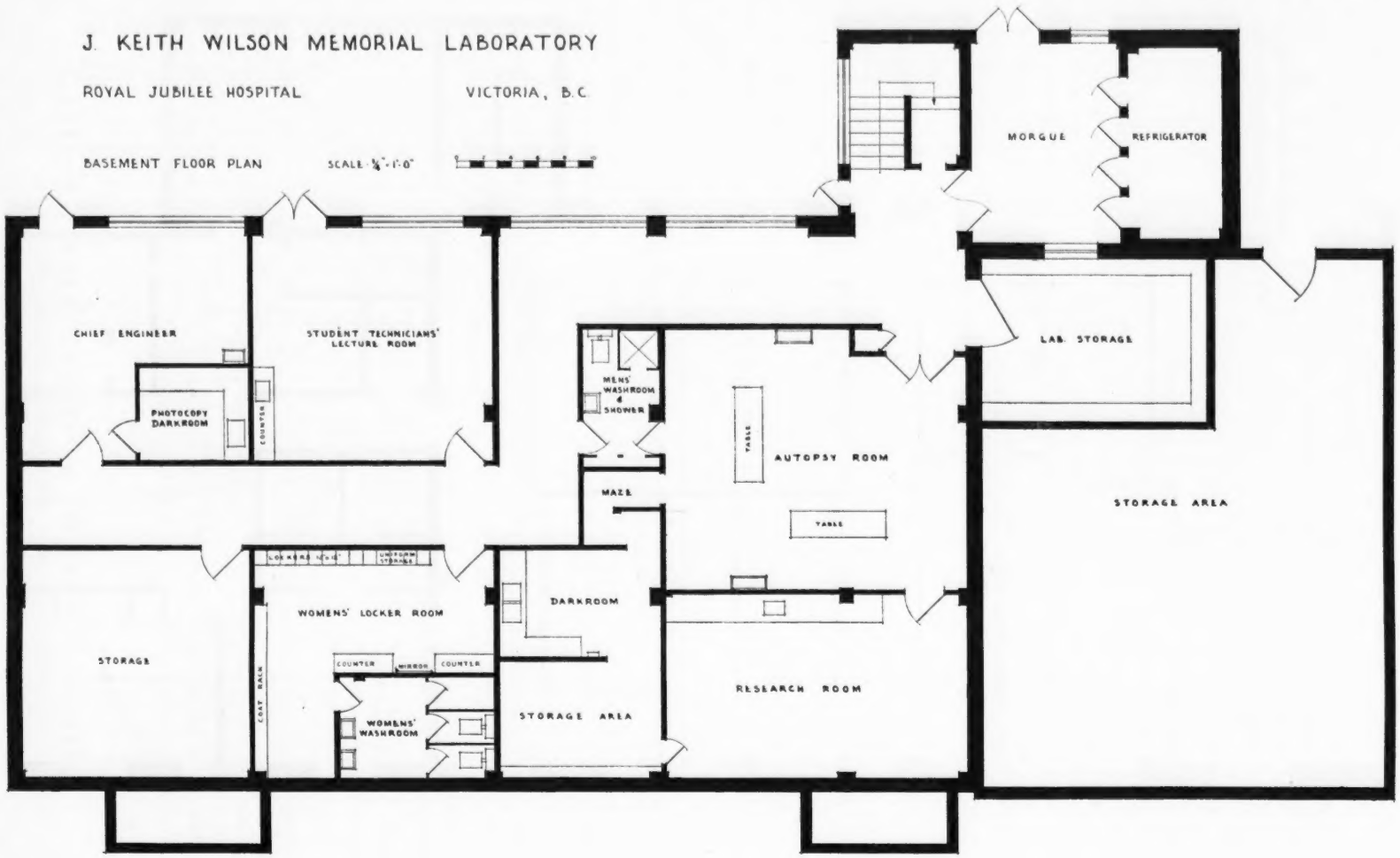
A splash of colour and a set of large mirrors in this staff room pay off in good employee relations.

H. Whittaker, M.R.A.I.C., Architect, Victoria, B.C.

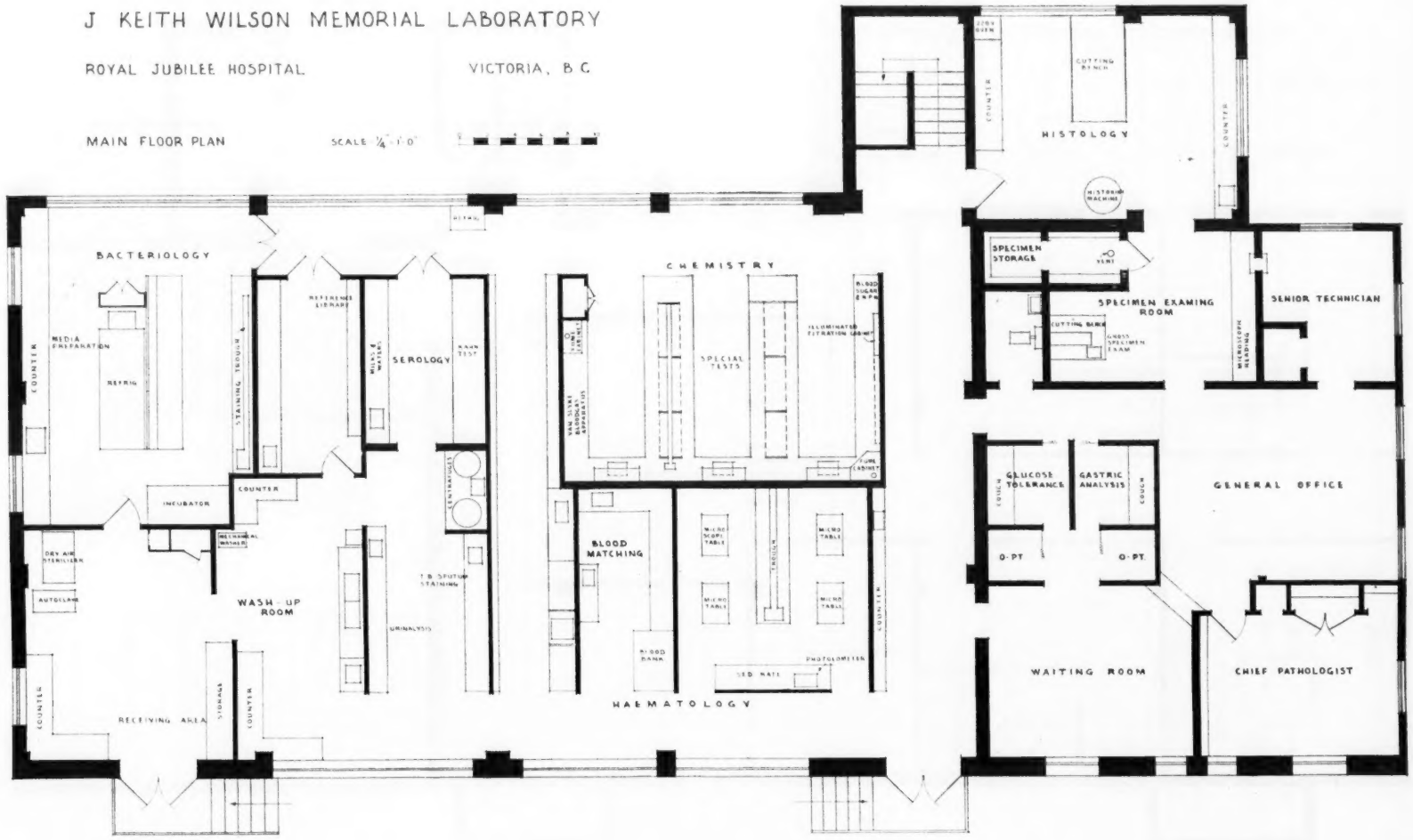
J. KEITH WILSON MEMORIAL LABORATORY

ROYAL JUBILEE HOSPITAL VICTORIA, B.C.

BASEMENT FLOOR PLAN SCALE: ⅛"=1'-0"



H. Whittaker, M.R.A.I.C., Architect, Victoria, B.C.



The Hospital's Man of Figures

Sister Saint-Georges,
Chief Accountant,
The Sisters Hospitallers of St. Joseph of New Brunswick,
Vallée-Lourdes, N.B.

MY PURPOSE here is to emphasize the importance of the accountant in hospital affairs. We all admit that the primary function of the hospital is the relief of the sick and injured; but can we overlook the part played by the business office? We are too apt to forget that our accountants are also performing vital tasks. Let the accountant be convinced that his work is just as important for the welfare of suffering humanity as is the work of the administrator, the doctor, and the nurse. All necessary activities depend on the business office. The patient needs care, comfort, and remedies. To obtain these requisites, financial means are essential. Hence the better the office functions, the more attention the patients will receive.

Functions

In order to illustrate the importance of the role of the accountant in the hospital, let us outline briefly his functions and responsibilities.

The accountant is the executive responsible for producing accounts, as well as facts and figures for the use of management. His functions may be concerned with general accounting, cost accounting, and internal auditing. The scope of his activities and responsibilities vary according to the size and organization of the hospital, as well as the organization of the business office itself.

Another responsibility is the preparation of accurate records and statistical data for administrative planning and outside agencies. In most small or medium-sized hospitals, the accountant is responsible for all office organization and all clerical work, including the selection of staff and office machinery necessary to perform the work. It is also required of the accountant, that he have the ability to choose and keep staff and, to this end, he must be capable of applying, consciously, such techniques as job evaluation and merit rating, in so far as they apply to clerical and administrative staff.

Depending on the size of the hospital, the accountant supervises the accounts payable clerk, accounts receivable, clerk, book-keeper, cashier, clerk typist, payroll clerk, stenographers, and miscellaneous clerical workers. He may also supervise storekeepers. In smaller hospitals he is often in charge of the admitting office and may handle details of general accounts receivable, accounts payable, and the payroll. Credit and collections are also under his care. These last two factors are of prime importance in the business office. The accountant should see that the person in charge of credit and collections makes use of much tact in his dealings with the patient. As credit manager, the accountant must be very tolerant, yet firm, in dealing with others. Above all, he must exhibit a humane attitude and naturalness of demeanor which will reveal him as a person with whom a patient would not hesitate to discuss his financial standing and ability to pay.

As Credit Manager

The task of the credit manager in a hospital differs so much from that of the credit manager in a commercial organization that it seems more logical, and I would add more gentle, to refer to him as the manager of the credit service department. A credit manager, in the usual sense, may choose to whom he will give credit but can this choice be made in a hospital? Patients are neither admitted nor refused admission on a basis of money. Above all, our hospitals are institutions both humanitarian and charitable; they are, in general, non-profit enterprises. Their credit managers have no choice in their credit extension. The poor as well as the rich have a right to recover their health; and the poor generally recover their health "on credit". It is for this reason that many well-informed authorities maintain that there is no room in a hospital for a credit manager in the true sense of the word.

The function of the accountant is also to provide information and it is especially in this role that he renders great assistance to the administrator. Accounting and figures are not an end in themselves, they are only a means to an end. It is not advisable that the accountant be the one who should take action on his figures; action is the responsibility of the administrator or management. Accounts and figures are inanimate things and can control nothing. It is the action taken in the light of and indicated by the figures that provides control.

The administrator stands at the top of the ladder but does not much of his success depend on the ability of the accountant? The accountant should always be ready to help the administrator in his responsibilities and thereby acquire a valuable experience. Let him not forget that he stands on a stepping stone to the top of the ladder. Candidates taking courses in hospital administration must study accounting because all administrators have to be familiar with both financial statements and the language of finance. Moreover, every accountant should have the desire to be an administrator. Otherwise, his mind is set on figures only and he is but a book-keeper. The accountant should familiarize himself with all the associated functions carried on in the hospital. We do not mean that he should be a doctor or a nurse but he could certainly know something about their work in the hospital.

There are many questions which the enthusiastic accountant should ask himself: Are the accounting reports and statements sumbitted to the administrator intelligently prepared? Do they give the vital information concerning the financial condition of the hospital and the results of its operation? Are comparative statements prepared? Is a budget prepared in advance? The administrator expects

An address presented at a Hospital Accounting Institute, sponsored by the Maritime Hospital Association, Moncton, N.B., November, 1952.

this information. If reports are not readily understood, graphs should be used. Lengthy reports should be broken up into several small ones. Information should be condensed and unnecessary details omitted. The form of many old reports might well be changed. Both originality and thought should be seen in the work of the qualified accountant. He should never stop learning.

Now, we must admit that many of the tasks of the accountant are not easy. However, these same tasks make the job far more interesting and, evenutally, more profitable to each individual accountant. Accountants should be convinced that they are playing an important part in an organization which appreciates and needs their best efforts in the expanding hospital field. Therefore, each accountant should strive constantly to improve this effort.

* * * * *

L'Homme des Chiffres

LE BUT de cette causerie est de souligner l'importance du comptable dans l'hôpital. Tous nous admettons que la fonction primordiale de l'hôpital est le soulagement des malades et des blessés; mais pouvons-nous meconnaître la nécessité d'une comptabilité intelligente dans le fonctionnement adéquat de nos hôpitaux? Nous sommes trop portés à oublier que nos comptables remplissent aussi une tâche vitale. En effet, que le comptable soit convaincu que son rôle est tout aussi important pour le soulagement de l'humanité souffrante que celui de l'administrateur, du médecin, et de la garde-malade. Un fonctionnement défectueux du bureau de comptabilité a sa répercussion sur toute activité nécessaire. Le patient exige des soins, du confort, des remèdes; pour l'obtention de ces choses indispensables des ressources pécuniaires sont essentielles: donc, plus le bureau fonctionnera bien, plus le malade aura de conforts.

Afin de faire ressortir l'importance du rôle joué par le comptable, faisons un bref résumé de ses fonctions et de ses responsabilités. Le comptable est l'officier responsable pour la présentation des chiffres et des rapports nécessaires à la bonne administration et aux projets en vue, pour le choix et l'entraînement d'un personnel de commis et d'administration, ainsi que pour les comptes de crédit et de perceptions. Le comptable a la responsabilité, de voir à ce que ceux qui travaillent sur le crédit et les perceptions se servent de tact et d'une attitude humaine. Notons ici que si le géran de crédit doit être ferme il doit aussi être tolérant et bienveillant dans ses rapports. Son attitude doit inspirer une confiance telle que le patient n'hésitera pas à lui exposer sa situation financière et ses moyens de solder un compte.

A proprement parler, il n'existe pas dans nos hôpitaux un gérant de crédit au sens où on l'entend habituellement. A cause de son caractère souverainement humanitaire et surtout charitable, parce que l'hôpital n'est pas en général une entreprise à profit, cette institution n'a pas le choix dans son extension de crédit. Que le patient soit en mesure de payer ou non, il sera admis si son état le requiert. On ne fait pas de distinction entre le riche et le pauvre et c'est ordinairement "à crédit" que celui-ci recouvre sa santé. En ce cas, ne serait-il pas plus logique d'appeler l'employé affecté au recouvrement des créances le gérant du "service de recouvrement" et non le gérant de crédit?

Dans son rôle d'informateur, le comptable donne le meilleur de ses services à l'administration, dont le succès, en grande partie, dépend du comptable. Au faite de l'échelle est l'administrateur, mais ne faut-il pas admettre que son succès, de beaucoup, repose sur l'habileté du comptable? Celui-ci, toujours disposé à prêter main-forte à celui-là allège les responsabilités de l'administrateur et s'enrichit d'expérience utile et parfois nécessaire. Les candidats aux cours d'administration hospitalières doivent étudier la comptabilité car tout administrateur doit se rendre familier avec les rapports et le vocabulaire financiers. De plus, chaque comptable doit être animé du désir d'être un bon administrateur. Il doit se familiariser avec tous les angles du travail de comptabilité d'un hôpital; autrement il n'est qu'un teneur de livres. Nous ne voulons pas insinuer qu'il devrait être un médecin ou une garde-malade, mais il devrait avoir des notions précises sur leur travail dans l'hôpital.

Nombreuses sont les questions que devrait se poser le comptable enthousiaste: Les rapports et les relevés de comptes soumis à l'administration sont-ils préparés intelligemment? Donnent-ils l'information vitale concernant l'état financier de l'hôpital et les résultats de son fonctionnement? Un budget est-il dressé préalablement? L'administrateur a droit à tout ce renseignement. Si les rapports ne sont pas compris, servons-nous de schémas. S'ils sont trop longs, divisons-les en sections. Apprenons à condenser et mettons de côté tout détail inutile. Changeons les anciennes formules des rapports d'autrefois. Et l'originalité et la réflexion doivent se manifester dans le travail d'un comptable habile. Jamais ne doit-il cesser d'étudier.

Maintenant, chers collègues, il faut bien admettre que plusieurs de ces tâches ne sont pas faciles; mais ne sont-ce pas ces mêmes tâches qui rendent notre profession intéressante? Finalement, ces tâches rendront en conséquence notre travail plus profitable à chacun de nous—ce qui n'est pas peu dire. Soyons convaincus que nous jouons un rôle important pour une organisation qui apprécie et qui demande notre effort le meilleur dans un domaine toujours progressant. Donc travaillons de tout coeur à l'amélioration de notre effort.—*Soeur Saint-Georges.*

Together We Serve

O. C. Trainor, M.D.,
President,
Canadian Hospital Council,
Winnipeg, Man.

ORGANIZATION may be defined as the coming together or integration of individual units in a form which enables them to achieve, collectively, aims and objectives which they could not carry out efficiently while acting as individuals. It should take very little thought to convince hospital people that there are many things that the individual hospital cannot do for itself. There would be little use in an individual hospital approaching a government with a suggestion for alteration in its general policy. If all hospitals in the province started to do something of the sort they would become an unmitigated nuisance. But if the hospitals get together, form an organization, and decide on a common objective, they are then in a position to approach such an authority with some hope of having their views given serious consideration. It is, therefore, obvious that a strong organization is essential for the welfare of all hospitals.

In Canada, it is a commonplace for institutions such as hospitals to organize in a fashion parallel to that in which governments are set up. First we have regional hospital organizations to consider their common needs and aims. These are then placed before the provincial organization by their appointed delegates and there scrutinized and compared with the recommendations of other such regional groups in the province. If found practicable and advantageous, appropriate action is taken to achieve the desired end.

To carry this a step further, the province needs representation in a national organization so that its views may be brought before the national body and considered with those of other provinces. If these views are such as to warrant support, united action may then be taken and the appropriate agencies of government approached for action on the national level.

The Canadian Hospital Council is an organization representing the provincial hospital associations and conferences of Canada and each has representation on the council. Meetings of the council — the policy setting body — are held every two years and its decisions are passed on to its board of directors for action in the interim. The aim of the council is to provide representation for all hospital interests and areas in Canada. If residents of any province have a problem or aim that requires action on the national level, these should be presented to your provincial representative who will urge your point of view before the directors. If they agree, the whole force and prestige of the council will be brought to bear in arriving at a solution.

Such functions require a national organization. The Canadian Hospital Council has grown slowly but soundly. It is a thoroughly democratic organization, controlled from the grass roots and there is no imposition of authority from above. It maintains an office with a staff of approximately 20 people who are busily engaged at all times in looking after the interests of the hospitals of Canada.

The Canadian Hospital Council publishes *The Canadian Hospital* which is recognized as one of the worthwhile publications in the hospital field. The council maintains and keeps up to date a reference and package library that is the best of its kind in this country. Information on any hospital problem is at all times available from this source. The C.H.C. recently embarked on an extension course in hospital administration which has achieved widespread recognition and promises to be a means of providing better trained and thus better qualified people for hospital administrative positions. The Canadian Hospital Accounting Manual, recently produced under the auspices of the Council, is now regarded as *the* authoritative publication in the field of hospital accounting in Canada. These are just a few of the specific activities the council has been able to undertake. The successful efforts of the council in having hospitals excluded from the provisions of the Unemployment Insurance Act has alone saved hospitals millions of dollars.

It is axiomatic that organization must be met by organization if we are to avoid uncontrolled bureaucracy which leads easily to tyranny. Hospitals are particularly and peculiarly in need of effective association able to safeguard the interests of the group. This is because hospitals must work constantly in close relationship with many people, more or less well organized in associations and unions which are seeking at all times to promote the interests of their members. To fail to protect the hospitals through meeting the interests of the individual would be to jeopardize the legitimate aims and objectives of the hospitals — the most important of which is the efficient care of the sick.

This program cannot be carried out without money and I trust you will bear in mind the essential nature of the Canadian Hospital Council and continue your loyal support. No individual association can afford to ignore its responsibility in this respect. To do so would have the effect of weakenng the Council to that association's own detriment. It has been said that continued vigilance is the price of freedom. To paraphrase that statement: continued activity in and support of your organizations is the unavoidable price of freedom for our hospitals.

To Build a Healthier Society

Present-day knowledge must be made available to all countries in order to enable them to assure adequate care for mothers, the best possible chance of survival for infants, and for children's normal physical growth and development as well as mental and emotional health . . . This is a big program. In order to carry it out, one essential condition must be fulfilled: all nations of the world, regardless of the political, economic or social systems to which they belong, must play their part in building a healthier human society. In our shrunken world isolationism in the field of health is unthinkable. Disease and misery in any corner of the world are a potential threat to the rest of its population. As far as health is concerned, it is obviously and immediately clear that the world will be one or none.—*Brock Chisholm*

Alberta Blue Cross Forges Ahead

J. A. Monaghan,
Executive Director,
Alberta Blue Cross Plan,
Edmonton, Alberta

(After many difficulties experienced in its formative years, the Alberta Blue Cross Plan has been steadily forging ahead. All of its obligations have been met and good progress is being made in accumulating the reserves considered actuarially sound by the Blue Cross Commission.

The current position of the plan was reflected in the annual report presented to the Associated Hospitals of Alberta by the Executive Director. That report, in part, is published here.—Edit.)

THE CONTINUED spread of so-called one-dollar-per-day plans, coupled with the certainty that Edmonton, one of the largest and most productive of Blue Cross territories, was to enter the municipal hospital field, resulted in the immediate initiating of a retrenchment program, Jan. 1, 1952, that was designed to create and maintain a sound financial position during the period that would be required for the complete assessment of a rapidly changing hospital picture within this province. That these economies were effective will be demonstrated in the results now reported for the fiscal period ended September 30, 1952.

While the operations of the Alberta Blue Cross Plan for the past year followed a pattern familiar to all Blue Cross Plans (increase in utilization of hospital care and steadily rising cost of service), it differs from the majority in a most important respect by having accumulated a substantial surplus.

Last year, subscriptions earned from active membership reached a new high total of $1,235,452.80; payments to hospitals totalled $981,846.34; and operational costs were $125,604.70. Earnings exceeded all expenditures by $130,063.56.

A review of the Plan's operations since inception shows that $3,548,440.30 have been earned; $2,816,514.04 have been paid to the hospitals of this province in settlement of subscribers' accounts and slightly more than one-half million dollars have been required for the operation of your plan.

At the present time, $175,000 are held in the general contingency and epidemic reserve. This fund is maintained by the Alberta Blue Cross Plan to meet the requirements of the American Hospital Association and the Blue Cross Commission. Under the licensing agreement by which each Blue Cross Plan is obliged to apply annually for re-approval and the right to use the Blue Cross emblem, certain standards must be met and maintained. One of these standards requires that 5 per cent of annual income for a period of five years or a sum equal to three months' earnings shall be maintained as a financial guarantee of a plan's solvency and ability to discharge contractual obligations to participating hospitals on behalf of subscribers.

Computed on this basis, the reserves of the Alberta Blue Cross Plan should be $247,000 and until such time as reserves are equal to, or in excess of requirements, the affairs of the plan should not be viewed with complacency. Neither should it be expected that further benefits can be given to subscribers, nor increased payments to hospitals without a compensating increase in contributions being made by subscribers.

To accumulate the necessary reserves within the required time, the Board of Trustees had the alternative of narrowing the present subscriber's contract and, as a result, reducing payments to hospitals or of reducing operational expense. The record will reveal no change in hospital-subscriber payment. The percentage cost of operations last year was 10.1 per cent as compared to 13.3 per cent in 1950-51; 13.1 per cent in 1949-50; and 20.5 per cent in 1948-49. The over-all percentage operating cost of 14.6 per cent, since inception, is within the range of similar-sized plans during the initial stages of development.

During the past year, operational cost, percentagewise, dropped from 18.5 per cent in November, 1951, to 7 per cent in September, 1952, and it is reasonable to predict that the plan will continue to function satisfactorily in the future, on operational costs of less than 10 per cent.

The marked rise in hospital costs again manifested itself tangibly last year when your association served notice on the Alberta Blue Cross Plan that a new uniform rate schedule was to be made effective on January 1st, 1952. Blue Cross members were served notice that rates would be increased on January 1st, 1952, to coincide with the date on which increased payments were to be made to hospitals. There was, and still is, general recognition of the necessity of such advances in rates. It is understandable that the increase in the subscribers' payment represents only a corresponding rise in wage scales and commodity prices; but it cannot be overlooked that these changes are costly and do involve heavy dollar expense to the Alberta Blue Cross Plan and, undoubtedly, certain losses in membership. Membership in the Alberta Blue Cross Plan totalled 114,099 participants on September 30, 1952, an increase of 3,591 over the total recorded one year ago.

This continued growth in membership, notwithstanding the increase in rates, the loss of perimeter enrolment areas and the absence of an active enrolment staff for ten months of the year, is readily acceptable evidence that the membership recognized the value of the Blue Cross Plan's contract.

Aggressive competition from many commercial carriers still continues within the province. Yet despite this pressure, losses are well within normal limits and should remain so, provided that the same generous contract, extending service rather than indemnity benefits is continued. Last year experience within this province saw Alberta included in the country-wide pattern of increased demand for hospital services.

Amongst the causes for growing

Oxygen Storage Unit

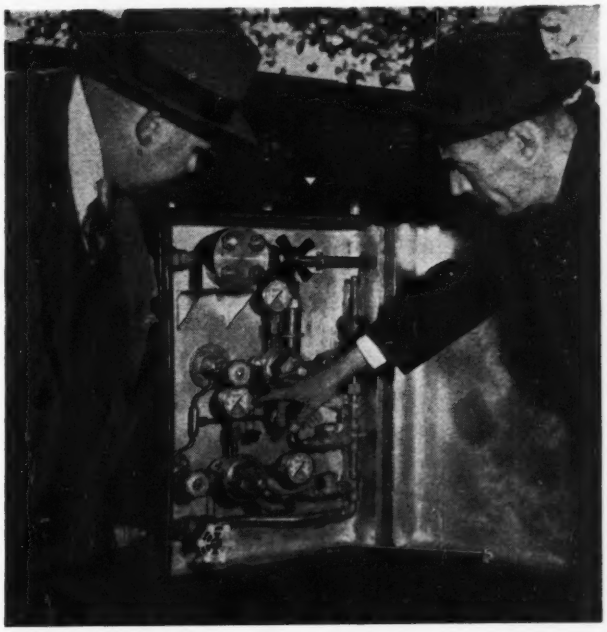
Oxygen Stored Out of Doors

at St. Mary's Hospital, Montreal

AMONG other innovations at St. Mary's Hospital in Montreal is its new central oxygen supply and distribution system. Oxygen is now stored in a 62-cylinder unit located outside the main buildings, as shown in the illustration. From there it is delivered at low pressure directly to all wards, private, and semi-private rooms. The oxygen is piped through a network of seamless copper tubing, concealed in ceilings, to an inconspicuous outlet at bed height. With the supply thus centralized, all oxygen therapy equipment has been placed under the care of a trained technician and servicing is done from one central point in the building.

The new installation provides each patient with a continuous supply of oxygen, uninterrupted by cylinder changing and also eliminates the hazards accompanying the handling of individual cylinders. The hospital will also experience substantial savings on oxygen purchases because of bulk delivery directly from a special tank truck to the storage unit.

Of the 62 cylinders in the unit, nine are always held in reserve and automatically turned on only while the remaining cylinders are being refilled from the delivery truck. Regular readings are taken from the unit's control panel to ensure that the oxygen is at all times sufficient to meet any emergency.



G. A. Daly, right, president of the Board, examines the new oxygen therapy control panel with G. J. Bartel, administrator.

←

pressure on hospital beds are: a more general appreciation of the value of hospital care; the trend in the medical profession requiring patients to be treated in the hospital rather than in the home; and the demand of the patient for hospital care already paid, accentuated by the increasing shortage of domestic help, and the wide acceptance of pre-payment health care plans such as Blue Cross.

Despite sound underwriting and careful selection of risk, payments to hospitals in settlement of subscribers' accounts are steadily mounting and the length of stay is increasing at an alarming rate. Not only is the individual bill larger, but there are now more of them to pay.

This is demonstrated by comparing

(Concluded on page 86)

Accountants from every part of the Maritimes enjoyed being students again.

Maritime Accountants Study New Manual

NEARLY 100 accountants and business office personnel from hospitals in New Brunswick, Nova Scotia, Prince Edward Island, and Newfoundland, gathered for a very successful institute on hospital accounting in Moncton, New Brunswick, November 25th to 27th.

The institute was sponsored by the Maritime Hospital Association with the assistance and co-operation of each of the provincial departments of health. Arrangements and program planning were carried out by the accounting committee, under the chairmanship of Walter W. B. Dick, C.A., accounting consultant to the Association and a partner in the firm of Hudson, McMackin, and Co. In handling local arrangements, the committee received generous assistance from Ruth Cook Wilson, executive director, and other officers of the Maritime Hospital Service Association. The fullest support was also given by the directors of the Maritime Hospital Association and its seemingly tireless secretary-treasurer, Mrs. Gladys M. Porter.

As the opening session got under way, registrants were welcomed on behalf of the Martime Hospital Association by Rev. Sister Catherine Gerard of Halifax. The advantages of uniform accounting were reviewed by Walter Dick who, in outlining the purpose of the institute, announced that it was dedicated to the "man of figures — the hospital accountant". The program was designed, he said, to familiarize the registrants with the contents of the *Canadian Hospital Accounting Manual.* Mr. Dick stated, in part: "In these sessions we intend to discuss the requirements of the Dominion Bureau of Statistics in the completion of annual financial and statistical reporting schedules. We stress, however, that the prime purpose of better accounting in the hospital is to provide administration with financial facts that are informative and stand the test of accuracy, adequacy, and appropriateness."

The landmarks in the development of hospital accounting and statistics in Canada, which led to the compilation of the *Canadian Hospital Accounting Manual,* were pointed out by Murray W. Ross, Associate Secretary of the Canadian Hospital Council. In this connection, he reviewed the efforts of the Council's committee on accounting and statistics and the accomplishments of the two Dominion-Provincial conferences on hospital statistics. He also discussed the general ledger numbering system, recommended in the manual, showing its flexibility and ease of adaptation in meeting the requirements and peculiarities of individual hospitals.

Revenue fund assets, liability, and surplus accounts were described in detail by P. Morris Blanchet, C.A., Controller, Saint John General Hospital. The revenue fund income and revenue fund expenditure accounts were discussed by Sister Louise Marie, Halifax Infirmary, and S. J. Bradshaw, St. Martha's Hospital, Antigonish, respectively. Walter Dick explained the purpose and operation of fund accounting as applied to hospitals and George H. Steeves of Moncton reviewed the funds other than the revenue fund, as outlined in the accounting manual.

An afternoon workshop, capably directed by Richard R. Rice of Moncton, traced actual entries for a sample hospital through the various journals and registers, the general ledger and trial balance and, finally, to statistical reporting Schedule III.

Statistical reporting Schedules I and II, covering general information and movement of patients, were described in detail by Gerald E. Clarke of the Dominion Bureau of Statistics, together with the revised definitions and instructions which accompany the schedules. The completion of Schedule III, finances, and the preparation of financial statements for administrative purposes, were described by Murray Ross. Review periods and question and answer sessions were under the chairmanship of R. W. Skeat, Moncton, and S. J. Bradshaw, Antigonish.

Excellent accommodation for the institute was provided in the club rooms of the Moncton Curling Association with adequate table space pro-

vided for each registrant. Meals were served in the meeting hall and, at luncheon and dinner meetings, stimulating addresses were presented by R. J. Tippett and Dr. D. F. W. Porter of Moncton, Dr. R. J. Dolan, Fredericton, Sister Saint-Georges, Vallée Lourdes, N.B. (see page 47); and at the final dinner meeting, Magistrate W. F. Lane delivered a most entertaining address entitled "Wit and Humour".

The Maritime Hospital Service Association tendered a reception and dinner to the delegates to the institute which was most enjoyable and much appreciated. The feature on this occasion was a broadcast address by Dr. J. A. McMillan of Charlottetown, chairman of the Board of Directors of the Maritime Hospital Service Association, on the philosophical approach to hospital and Blue Cross relationships. Following his address, Dr. McMillan presided over a round-table discussion on related problems.

At the final dinner meeting, certificates of attendance were presented to the registrants by Neil McLean, Charlottetown, president of the Maritime Hospital Association, assisted by Mrs. Gladys M. Porter.

The representative and enthusiastic group of accountants assembled, the excellent conditions under which the sessions were held, the detailed planning and program preparation by the executive of the Maritime Hospital Association and its Accounting Committee, and the ever-ready helping hand from representatives of Hudson, McMackin, and Company, and Blue Cross, combined to make the institute very pleasant as well as highly profitable.—*M. W. R.*

Top to bottom: Eager attention is displayed at this session.

Exchanging smiles are: Arnold Wightman, Montague, P.E.I., left; P. M. Coffey, Fredericton, N.B., centre; and H. J. Delaney, Moncton, N.B., right.

In this happy group, from left to right, are: Mary Mattinson, Glace Bay, N.S.; Ernest G. Mabley, Moncton; Mrs. D. O. Downing, Moncton; Myra Watson, Sydney, N.S.; Grace Edwards, Digby, N.S.; and John E. Cullen, Charlottetown, P.E.I.

Who told the joke? Enjoying it are left to right: W. Gemmel, Yarmouth, N.S.; W. Hickey, Summerside, P.E.I.; D. O. Downing, Moncton; Gerald E. Clarke, Ottawa; and Professor R. P. Donkin, Halifax.

In animated discussion are, left to right: K. E. Irvine, St. Stephen, N.B.; A. F. Carr, Campbellton, N.B.; T. L. Doyle, Moncton; and Murray W. Ross, Toronto.

In Montreal . . .

Accounting Personnel Concentrate on Cost Analysis

THE first institute to be devoted largely to the study of cost analysis, since the publication of the *Canadian Hospital Accounting Manual*, took place in Montreal, December 2nd to 4th. It was sponsored by the Montreal Hospital Council, with detailed arrangements in charge of an institute committee comprised of A. H. Westbury, chairman, Gerard Brais, Maurice Duhamel, and Charles D. Love.

A. V. Harris, lecturer at McGill University and a partner in the firm of Riddell, Stead, Graham and Hutchison, lectured on the principles of cost accounting. Mr. Harris divided this subject into three main divisions dealing with the allocation of costs for material, labour, and overhead, giving particular emphasis to stock control and distribution.

Walter W. B. Dick and Richard R. Rice of Hudson, McMackin and Company, dealt with both the theory and practice of costing and cost analysis. Using sample forms adapted from Chapter 13 of the *Canadian Hospital Accounting Manual*, the various steps of analyzing and distributing hospital costs were followed through. In addition, alternative methods and bases for distribution were discussed.

Gerard Brais and A. G. Thom, chief accountants of Hôpital Notre-Dame and Montreal General Hospital, respectively, outlined in some detail costing systems in use in their own hospitals and indicated wherein they would be making certain changes to bring their procedures more closely into line with those recommended in the manual.

The recording and reporting of general hospital statistics, which had been studied by the same group at an institute in June, were reviewed and the revised reporting schedules and revised definitions and instructions for their use were re-examined, under the leadership of B. R. Blishen of the Dominion Bureau of Statistics.

Budget preparation and control, as outlined in Chapter 14 of the manual, was discussed by Murray Ross of the Canadian Hospital Council. Again, sample forms illustrating the various steps recommended were utilized. The use of mechanical equipment and several business systems, the subject matter of Chapter 15 of the manual, formed the basis of a very interesting address by A. E. Bishop, a partner in the firm of P. S. Ross and Sons.

Under the chairmanship of A. H. Westbury, lively round-table discussions, dealing with accounting and related procedures in the hospital, were held in the evenings. Officials of the Montreal Hospital Council presiding over the general sessions included: Joseph H. Roy, president, Dr. J. Gilbert Turner, Dr. G. Cousineau, Samuel S. Cohen, H. D. Jack, and Dr. Edmond Dubé. At the conclusion of the sessions, certificates of attendance were presented to the registrants by Mr. Roy.

The institute was conducted in the English language and provided accountants of the English hospitals, and a number of French hospitals, in Montreal and elsewhere in Quebec, an opportunity to assemble for group study and discussion. That the registrants found the sessions highly profitable was indicated by their decision to recommend to the Montreal Hospital Council the formation of an accounting section through which accounting personnel would meet at regular intervals to discuss mutual problems. It is also planned to establish a committee on accounting and statistics at an early date to work as a liaison group with the Committee on Accounting and Statistics of the Canadian Hospital Council under the chairmanship of Walter Dick.—*M. W. R.*

Walter W. B. Dick, general chairman of the accounting institute committee, Maritime Hospital Association, also spoke at the Montreal Accounting Institute.

Organizing Civil Defence in British Columbia

Among civil defence projects to be financed jointly by the federal and British Columbia governments is one which will provide for increased staff in the provincial departments, responsible for organizing civil defence health and welfare services. The sum of $6,200 is to be expended for salaries of a director of services and a civil affairs health officer (part-time) and for travelling expenses for these officials. A welfare officer will also be employed in organizing municipal health and welfare services on a uniform basis throughout the province.

Hospital Credit and Collections

Part I

CREDIT and collections, as related to hospitals, concerns the determination of an individual's intention and financial ability to pay for hospital care, as well as the methods which may be used to effect payment of the account. At all times the intangible but very valuable element of good will must be considered since the business of extending credit and effecting collections, if not diplomatically and tactfully managed, may prove detrimental to the hospital's reputation and standing in the community. It is a matter of taking care of the sick and, at the same time, keeping the hospital open and solvent.

Well defined policies and rules should be established with regard to the extension of credit and the collection of unpaid accounts. Such policies should be approved and passed by the governing board of the hospital. It is then the duty of the administrator or superintendent to see that they are properly carried out.

Rules and Procedures

The common errors in a goodly number of hospitals are usually traceable to laxity of rules or laxity in the following out of the established rules. These are made both at the time of admission and in the follow-up after discharge. When establishing credit and collection rules and procedures, the following should be considered:

1. Method of informing prospective patients and the attending doctors of hospital charges and rates;
2. Method of determining credit rating at time of admission;
3. Billing and collection procedures while in hospital;
4. Financial arrangements at time of discharge; and
5. Follow-up routine in collection procedure after patient's discharge.

Too many patients are problems at the time of admission to hospital because they have not been properly informed prior to admission as to what is expected or required of them. Thus it is the business of the hospital to provide a means of enlightenment for the people of the community. This can be done through the medium of a pamphlet or brochure listing pertinent data about their hospital, including detailed information concerning the payment of accounts, visiting hours, responsibility for valuables, et cetera. Such information, circulated through doctors' offices in the community, with a word of advice from a patient's well-informed family doctor, would help to facilitate the work of the admitting department at the hospital.

George McQueen,

Office Manager,
Hamilton General Hospital,
Hamilton, Ont.

The patient's attention may later be directed to an attractively printed, well-worded card posted in the room, noting the charge for a day's care, as well as other data concerning hospital rules and regulations.

A great deal can be achieved by thoughtful consideration on the part of the hospital, the doctor, and the patient. There must, however, always be closest co-operation.

Procedure at Time of Admission

The maxim of retail credit men is that an account well opened is half collected. Applying this to hospital business which is, of course, somewhat different from normal credit business, we believe that the information received at the time of admission is of the greatest help and importance.

It is a well-known and understood fact with most of us that first impressions are generally lasting ones. An individual's first impression of the hospital is often based on the manner in which he was received by the admitting department and the admitting clerk. It is very important to all hospitals, regardless of size, that this responsibility be placed in the hands of a well-trained, competent, and understanding person. Patients applying for admission are ill and are often emotionally disturbed, so that care must be exercised in obtaining the necessary credit information. Such care and courtesy should also be shown to relatives because they may be as upset as the patient.

A private office should be provided where confidential discussions may be held without embarrassment to the person being interviewed. A well-planned admission form should be used, with sufficient copies for the business office, medical records, et cetera. In obtaining information, keep control of the conversation, note all the questions, and obtain as much detail as possible. It is important to get the first name of the wife of the patient and the last place of residence. These are common omissions that may prove important if collection procedure is a necessity at a later date. Intimate the ward and room and, if possible, have the patient ask the rate. When quoting rates say "for a day's care" or "a week's care", not the old familiar phrase "for room and board". Obtain a signature of verification on admission. Through not being properly informed, a patient may request accommodation which he cannot afford. It then becomes the duty of the interviewer to persuade or advise the person to accept accommodation within his means and thus prevent future embarrassment and an unpaid account. When doubt exists as to ability to pay, a special form may be used to obtain a more detailed financial report. This should be made in sufficient copies to notify all departments concerned of the arrangements made.

The duties of the admitting clerk, credit manager, or person responsible for credit ratings may be summarized as follows:

1. Explain hospital charges and collection

An address presented at a regional conference of the Ontario Hospital Association, London, Ont., May, 1952.

policies to person responsible for payment of account;

2. Determine the individual's financial ability to pay;
3. Obtain sufficient information for future reference should account be unpaid;
4. Recommend rate reductions or arrange for reductions when warranted;
5. Determine the responsible person or agency for payment of hospital bill;
6. Arrange installment payments if, and when, necessary; and
7. Arrange for some responsible party to guarantee patient's account when necessary.

This work is time-consuming and is assigned to various individuals depending on the size of the hospital. In larger hospitals, a person is employed full-time as credit manager; while in small hospitals credit ratings are usually determined by the superintendent. Regardless of who is responsible, the major consideration is to have the work assigned to one qualified to handle it efficiently and effectively.

Payment in Advance

I like to think of payment in advance in terms of an admission deposit. The deposit serves a two-fold purpose. First, it shows the patient's willingness to pay and, second, it is indicative of his financial responsibility. For a number of years a great many hospitals have followed the policy of asking an admission deposit and I believe the idea is justified because hospitals have not always a means of determining credit ratings on patients prior to admission. Then, too, hospitals are selling service and are not in a position to recover merchandise. Such a policy would not need to apply to patients covered by Blue Cross, Workmen's Compensation Board, or other responsible third parties. It would, therefore, apply to a relatively small percentage of admissions; yet it is in this small segment of our patients that the greatest number of credit problems arise.

There is usually no better opportunity to ascertain the financial responsibility of a patient than at the time of admission. It is then that the admitting clerk, on learning that the patient's account is not guaranteed in a substantial amount by insurance or otherwise, tactfully advises the patient that an admission deposit is desirable and that his account is to be paid in full on discharge. Most patients, when requested to pay a deposit, expect to do so and are prepared. The admitting clerk then can sense the credit problem if payment cannot be made or is refused. The patient is admitted but it is a signal to refer the case to the credit manager that day or as soon as possible.

Setting a definite amount for an admission deposit is better policy than to base the charge on, say, rates for one week or to attempt to assess the total bill. The average stay may be one week but fixed routine charges, such as laboratory fees, et cetera, would have to be added to the charge for patient care for that period. Again, accurate estimates of the patient's total bill are difficult to make in these days; and such estimates would add to the confusion of the hospital, staff, and patient. On the other hand the specific-amount method of admission deposit maintains a more definite control of possible delinquent accounts, particularly in times when collections are harder to make.

Procedure While in Hospital

After the patient is admitted, it is the responsibility of the accounting office to arrange collections during the patient's stay. All pertinent data relating to the guarantor and credit arrangements, taken on admission, should be noted on the patient's ledger account. The work of the admitting officer in determining credit ratings will be of little value if the accounting department does not render accounts promptly and in accordance with the terms agreed to on admission. Prompt notification of the credit manager, or the person responsible, concerning delinquencies in payment of accounts will often determine the degree of success the hospital will experience in collecting during the patient's stay.

Where payment is not made according to the hospital's policies, some authorized and qualified employee should arrange to interview either the patient or a responsible relative. In some of the larger hospitals, ward clerks are now a part of the regular staff. They are, under supervision, directly responsible for the detailed clerical work on the ward, thereby releasing nurses for other duties in the more direct care of the patient. A ward clerk can be of great assistance and value to the accounting office by acting as a liaison between the office and the patient. She can be responsible for the tactful approach to patient or relative with a statement of account and the timely reporting of action and response to the weekly accounts. Being in more or less direct contact with the progress of the patient, she can verify the various service charges and, on the day of discharge, notify the departments rendering services that day, so that charges can be sent to the business office prior to the compiling of the final account. This system can go a long way in eliminating the universal problem of late charges, following the discharge of a patient.

The accounting office requires the full co-operation of all departments to accomplish the best collection results. Take time and opportunity to enlighten the nurses and staff in other service departments concerning the reasons for procedures followed in assuring payment of the patient's account.

(to be continued next month)

Alberta's Catholic Hospitals Convene

On Oct. 14th, the Catholic Hospital Conference of Alberta met in Calgary. Rev. H. F. Légaré of Ottawa, newly-appointed executive director of the Catholic Hospital Council of Canada, was present for the meeting.

Addressing the conference, Murray Ross, associate secretary of the Canadian Hospital Council, reminded delegates that a major factor in the operation of any hospital is human relations. He pointed out the importance of relating the hospital to the five "P's"—patient, physician, personnel, public, and publicity.

New slate of officers for 1952-53 includes:

President: Sister Mary Helen, St. Joseph's Hospital, Barrhead;

First Vice-president: Sister St. Ovide, Misericordia Hospital, Edmonton;

Second Vice-president: Sister John, Providence Creche, Calgary;

Secretary-treasurer: Sister St. Rodolphe, Misericordia Hospital, Edmonton;

Nursing Committee Chairman: Sister M. Beatrice, Lethbridge

Administration Committee Chairman: Sister M. Adele, Camrose

Executive Secretary: G. Amerangan, 531 Tegler Bldg., Edmonton.

Food and Its Service

Sponsored by
The Canadian Dietetic
Association

A Revised Teaching Program

G. Gwendolyn Taylor,
Director of Dietetics,
Strong Memorial Hospital
University of Rochester,
Rochester, N.Y.

THE gradual increase in the number of diseases now dependent on dietary treatment has fortunately forced us into re-organization of the preparation and service of the so-called "special diets". In the past 25 years our ideas on planning therapeutic diets have changed and I think we can say we have improved our approach. Today a modification of the normal diet is suitable for most cases requiring special consideration.

In our own experience the actual number of patients receiving special dietary treatment has markedly increased in the past five years and at the present time 20 to 25 per cent of the total number of patients require a special dietary regime.

In 1940 some major construction was done at our hospital, at which time a "special diet" kitchen was completely equipped with stove, steamer and the necessary equipment to prepare the diets. Today such space would be used to much better advantage although some area in the main kitchen would be set aside for the making of tube feedings, special fluid feedings, et cetera. The diet kitchen employees included a cook, assistant, and other helpers. In addition, the student nurses, varying in number, were assigned to the diet kitchen. They also assisted in the actual preparation of food. When our diets increased to the point where our diet kitchen was inadequate, we decided, after much deliberation, that the only solution was to prepare the food for the therapeutic diets with the rest of the food for patients. Fortunately, our chef, who is over retiring age, is still progressive and he was quite willing to take on the added responsibility. While the change has taken place within the past year, we feel the new plan has been very satisfactory. Before we made the change, we spent considerable time in drafting a master menu and we are convinced that well thought out menus are the key to the success or failure of the plan. You may not be experiencing the acute shortage of good employees that we are; but we felt we could not add a great deal of extra work to that of our busy staff of cooks, so kept this in mind as we planned our menus.

Some of you may have used the master menus as printed monthly in *Hospitals*. We worked our menus out on a similar plan. If the person or persons planning the menu can visualize the whole picture, you will have no trouble. For example, will your choice of meats, vegetables, desserts, et cetera, look after the bulk of your diets? The fact that most of our patients are on standardized diets as outlined in our diet manual, undoubtedly simplifies the menu.

Some additional small equipment was purchased, such as small stainless steel pans to fit the meat tray in our hot food trucks. Actually, the number of dishes required was greatly reduced as previously each individual diet had been sent to the floor as a unit. Now the food goes up in bulk, *e.g.*, the total number salt free meats for one floor is sent in one container. The additional servings are added to the cook's work sheets as are also the extra food items. When the food trucks are checked out at each meal, all patients' food can then be accounted for.

Unfortunately, we are still dependent on the nurses for food service, on the majority of our divisions. It is therefore necessary to send a menu for each patient on special diet so that no mistake will be made in the foods the patient receives. These menus are mimeographed and a slip checked for each patient.

For Student Nurses

Each change in organization in a department usually necessitates other adjustments. This was the case in our teaching program for the student nurses. Have any of you, on a hospital staff, overheard this kind of conversation in a group of young student nurses? "Where are you on duty now?" and the reply has been "Oh! the diet kitchen" in a rather disgusted, disinterested tone. Haven't we dietitians been responsible in many instances for this attitude of the young nurse? Why have we failed to make the nurse realize that nutrition is just as necessary a part of treatment as a drug, physiotherapy or other treatment? One apparent reason is that until recently in many hospitals the nurses spent most of their time in the dietary department preparing food, which could have been prepared by a dietary employee. Again, too often the dietitian doing the teaching is not fully qualified to do it. Here is a special field where extra training is required, if we are going to do a good job. Few recent graduate dietitians have the background or experience to give a good course of instruction; and yet sometimes the teaching is done by an inexperienced graduate.

Curriculum

While each hospital has to work out a teaching program to fit in with the nurses' curriculum, you might be interested in our outline. During the preclinical period, which I first knew as the "Probie Period", a course in normal nutrition is given, which includes 15 hours lectures, 30 hours laboratory. A one-hour written examination and two-hour practical examination are included in these hours. This course is given in preference at the end of the chemistry course; but sometimes the chemistry has not been completed before we start our instruction.

In the second year 17 hours of diet therapy lectures are given concurrent-

An address presented at the dietetic section, Ontario Hospital Association Convention, Toronto, October, 1952.

ly with the medical and surgical lectures. A mid-term and final examination are included. In future we propose to have a short laboratory period to replace the practical experience in the diet kitchen so that the nurses will become familiar with the preparation of foods pertaining to special diets. Two hours in obstetrical teaching are given — one hour on normal, one on abnormal. In paediatrics a three-hour lecture and laboratory period on infant feeding is given. In addition 4 hours of lecture on therapeutic diets for children are included.

The dietary practice in most instances is given also in the second year. Each student is assigned 4 weeks to the dietary department. During this time, the student spends 12 hours in the formula room, as in our hospital the formula room is the responsibility of the dietary department. Our regular employees make the formulae and the nurses observe and actually prepare them for a short period only. Usually 4 students are assigned to the department at one time. When these students come to us at the beginning of their second year, they require considerable instruction as they have not had their medical and surgical lectures, nor their diet therapy. A short orientation period is given the first week — usually 3 days. The adequate diet is reviewed, routine hospital diets are discussed in detail and the therapeutic diets most frequently used are dealt with.

A procedure book and the Dietary Manual are available for the student nurses. Assignments are given as follows: reading references, texts and journals; dietary questionnaire to be handed in and reviewed with student; and dietary case study to be presented during the 4th week.

The director of nursing education and the director of dietetics attend this conference.

The students' experience includes:

(a) Writing diets — medical, surgical, low salt, diabetic, et cetera;
(b) Visiting patients on therapeutic diets;
(c) Visiting patients on private floors, where they collect menus;
(d) Supervision of tray service and ordering supplies for specified floors;
(e) Checking all floor refrigerators for supplies;
(f) Preparing tube feedings, high caloric and other special fluid feedings, and preparing some salt free desserts and salads;
(g) Attending diabetic and food clinic and making displays for same;
(h) Going on division medical rounds two afternoons a week, when assistant residents review progress of patients on special diets.

In the third or senior year we are assigned no time at present. However, in the near future we expect to have some time allotted to us. Newer knowledge of nutrition will be discussed as well as food budgets and other information which will be helpful to the nurse, who will soon be a graduate. The nurse will also attend Food Clinic to learn any newer trends in teaching the patient. A comprehensive examination in the senior year includes questions on dietary practice.

Advantages

Let us briefly see what the advantages are in this newer dietary teaching program. Probably the fact that the nurse likes it and feels she is really learning something would come first. It has put nutrition and diet therapy on the same level as anatomy, nursing arts or other subjects on the curriculum. As the whole training of the nurse centers around the patient, she realizes that good nutrition is actually necessary if the patient is to be restored to health. On graduation, the nurse may remain on the hospital staff or she may enter the public health field or do some other type of work. The nurse who understands the normal diet and its modifications is better equipped to enter any field. In our teaching program I like to think of the nurse as an "ambassador" of the dietary department. Since she has a direct contact with the patient she can suggest some substitutions if the patient is unhappy or unable to take some items on the menu and she also sees that correct dietary orders are given for each patient.

I hope I have not given anyone the impression that our training program is the ideal one. It is still in the experimental stage and I know will be improved in the next few years. There have been some timely articles published recently on this subject and if you have not read them I would recommend them to you. In the September, 1952, issue of the *Journal of the American Dietetic Association* there are two articles: "Changing Concepts in Teaching Nutrition to Nurses", by Hendrika J. Rynbergen, New York Hospital; and "The Nutrition Education of the Nurse", by Madge Meyers, Ohio State University Hospital, Columbus. In the January, 1952, issue of the *American Journal of Nursing*, "New Ways to Study Nutrition", by K. U. Betzold and G. Elfert, Johns Hopkins Hospital.

In closing, I cannot but stress the fact that we, as dietitians in the hospital field, should do everything to elevate the nutrition teaching so that our subject will have its rightful place with the other sciences in the nursing curriculum. This can only be done if qualified teaching dietitians can present a well-planned program.

Demonstration of Audio-visual Teaching Aids

When the School of Hygiene at the University of Toronto held "open house" on December 4th, the department of hospital administration, which is headed by Professor Harvey Agnew, played an effective part in the evening's program. A motion picture, "Fire Hazards and Your Hospital", was well attended; while the display of audio-visual teaching aids attracted and held a large number of visitors.

The classroom was gay with bright coloured posters and well arranged pictures which showed interior as well as exterior views of a number of new hospitals. Architectural features were also demonstrated by a judicious selection of floor plans, elevation sketches, and models. There were administration charts to be examined; while visual symbols revealed how the hospital dollar is spent and in what proportion for each service. Visitors eyed the latter, especially, with frank curiosity and many stayed to seek further information or enter into discussion.

While the purpose of such a demonstration is to give visitors an opportunity to learn something of how and what students in hospital administration are being taught, as one activity of the School of Hygiene, it is also a public relations medium of value to the hospital field at large. The well-arranged program for this department was under the direction of Professor Eugenie Stuart. ●

◄ Notes About People ►

Director of Nurses Retires from Vancouver General Hospital

Elinor M. Palliser, director of nurses at the Vancouver General Hospital, retired on Oct. 15th. She is succeeded by Helen M. King, who has been assistant to Miss Palliser.

Appointed as director of nursing in 1943, Miss Palliser will long be remembered at the hospital for her spirited campaign for a new residence for student nurses. The residence, the first unit of which was opened in 1951, is one of the largest on the continent.

Born in Lachute, Quebec, Miss Palliser taught school before entering Johns Hopkins Hospital in Baltimore, Md., as a student nurse. Later she enrolled in McGill University for a course in teaching and supervision.

* * * *

Paul D. Shannon, C.A., Appointed to Royal Victoria, Montreal

The Board of Governors of the Royal Victoria Hospital, Montreal, P.Q., have announced the appointment of Paul D. Shannon, C.A., to the position of controller. Mr. Shannon, formerly executive secretary of the Associated Hospitals of Manitoba, commenced his new duties on January 15th.

Mr. Shannon attended Wesley College in Winnipeg, Man., and the University of Manitoba. During World War II, he served overseas at Canadian Military Headquarters, with the rank of staff captain. Later he was associated with a firm of chartered accountants. In 1950, Mr. Shannon joined the Associated Hospitals of Manitoba as secretary and consulting accountant.

Paul Shannon

* * * *

Staff Changes Announced At Oshawa General Hospital

The Board of Directors of the Oshawa General Hospital have announced the appointment of W. A. Holland, formerly business manager of the hospital, to the position of superintendent. Mary Bourne, who has been superintendent and director of nurses, has resigned from the former position in order to devote full-time to the responsibilities of director of nursing in a growing institution.

Mr. Holland is a native of Oshawa and received his education there. He was employed with the Dominion Bank for two and a half years and later obtained business experience in the statistical and customs department of General Motors of Canada Limited as well as with the War Supplies, Ottawa. In 1945, he joined the staff of the hospital as office manager and was promoted to the position of business manager in June, 1947.

Miss Bourne joined the staff of the hospital as instructor of nursing and assistant to the superintendent in Sept., 1940. In 1946, she was appointed acting superintendent and in 1947 became superintendent.

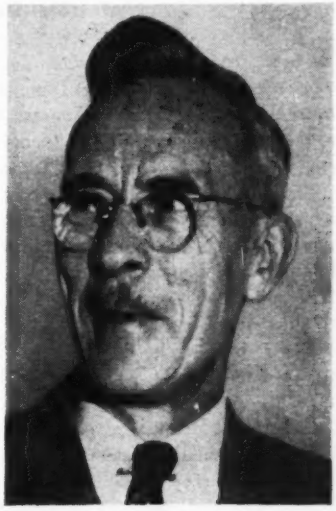
Dr. Ernest Couture Resigns from Federal Health Department

Dr. Ernest Couture, known to thousands as the author of *The Canadian Mother and Child*, has resigned as director of the child and maternal health division of the federal health department in order to return to private practice in Ottawa. Prior to joining the federal health department, Dr. Couture specialized in the practice of obstetrics in Ottawa. He organized the maternity department of the Ottawa General Hospital and was in charge of this service for 15 years. He was on the staff of the obstetrical department of the Ottawa Civic Hospital and on the medical consultant staffs of the Ottawa General, the Ottawa Civic, and the Sacred Heart Hospital, Hull. For three years, he was in charge of the Ottawa Child Health Centre.

While with the federal health department, Dr. Couture prepared his textbook, *The Canadian Mother and Child*, which attained a circulation of nearly 2,000,000 copies. He has also written numerous articles on his speciality for journals of medicine and public health. In 1948, he was Canada's alternate delegate to the session in Geneva which saw the organization of the first Assembly of the World Health Organization. Dr. Couture graduated in medicine from McGill University, Montreal, and took his post-graduate training at the Lying-In Hospital, New York.

New Executive Secretary-Treasurer Saskatchewan Hospital Association

On Jan. 1st, Edward Victor Walshaw, formerly assistant superintendent of the Saskatoon City Hospital, assumed his new duties as executive secretary-treasurer of Saskatchewan Hospital Association. He succeeds John Smith of Yorkton, Sask., to a position which has now become a full-



E. V. Walshaw

time, permanent post.

Mr. Walshaw has devoted 28 years of service to the Saskatoon City Hospital. He joined the staff in 1924, immediately following his arrival in Saskatoon from Sunderland, England. He began as a ward orderly, was named head orderly in 1927, became house steward in 1932, purchasing agent in 1941, and in 1946 was named administrative assistant. From 1948 until his resignation, Mr. Walshaw had been assistant superintendent. In accepting his resignation, the City Hospital Board expressed gratitude for his "long and faithful service".

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Manitoba Blue Cross Plan Announces New Appointment

The Board of Trustees of the Manitoba Hospital Service Association have announced the appointment of Frank D. MacCharles as executive director succeeding A. L. Crossin. Mr. MacCharles retired recently from the position of actuary and general manager of the Great West Life Assurance Company. He has been associated with this company for the past 41 years. Mr. MacCharles is not new to the field of prepayment plans for hospital care. He was a member of the first organization committee for Blue Cross and became a member of its first board of trustees, continuing this service for several years. He assumed his new position on Nov. 1st, 1952.

Upon his resignation as executive director of the Manitoba Hospital Service Association, A. L. Crossin was elected to the Board of Trustees of the association. He was chairman of the first organization committee for a Blue Cross Plan in Manitoba and became chairman of the first Board of Trustees in Jan., 1939. On Aug. 1st, 1939, he undertook the duties of executive director.

* * * *

Jennie Webster

A familiar figure at the Montreal General Hospital, Montreal, P.Q., Jennie Webster, O.B.E., died at the age of 89, last October. Night superintendent for 33 years, Miss Webster occupied a small suite in the hospital in later years. She had retired from the hospital staff in 1933.

In 1892, Miss Webster began her nursing career when she entered the Montreal General Hospital's school of nursing. The school had been established just two years previously. When she graduated, Miss Webster became lady superintendent of the Civic Hospital for infectious diseases. In 1900 she came back to the Montreal General as night superintendent. Shortly after she retired, Miss Webster was made a member of the Most Excellent Order of the British Empire.

* * * *

Tributes to the late Sister Kenny

Sister Elizabeth Kenny died on December 1st, 1952, at her home in Toowoomba, Queensland, at the age of 66. She was buried in the heart of the bush country where she worked out her famous methods of treating infantile paralysis.

Tributes have poured in from state and church officials praising the service and devotion of this Australian nurse. Rt. Rev. Dr. R. C. Halse, Bishop of the Church of England, Brisbane, Australia, said: "She left behind an example of devoted service toward the cause of alleviating suffering. Many benefitted from her methods."

* * * *

● H. Robert Cathcart, who has been acting administrator of the Pennsylvania Hospital Department for the Sick and Injured, Philadelphia, Pa., since May, 1952, has been appointed administrator. Mr. Cathcart is a graduate of the course in hospital administration at the University of Toronto, Toronto, Ont.

* * * *

● Dr. F. D. Sowby of the Charles Camsell Indian Hospital, Edmonton, Alberta, has been named winner of the Alberta Tuberculosis Association's 1952 fellowship of $1,200.

Lakehead Hospital Council Announces New Officers

Dr. George S. Jeffrey of the Fort William Sanatorium, Fort William, Ont., has been appointed president of the Lakehead Hospital Council. This organization is composed of representatives from the hospitals of the Fort William — Port Arthur area. Other officers are: vice-president, Alice Hunter, Port Arthur General Hospital; secretary, Christina L. Keehn, Port Arthur General Hospital; and chairman of the program committee is Sister Patricia, St. Joseph's Hospital, Port Arthur.

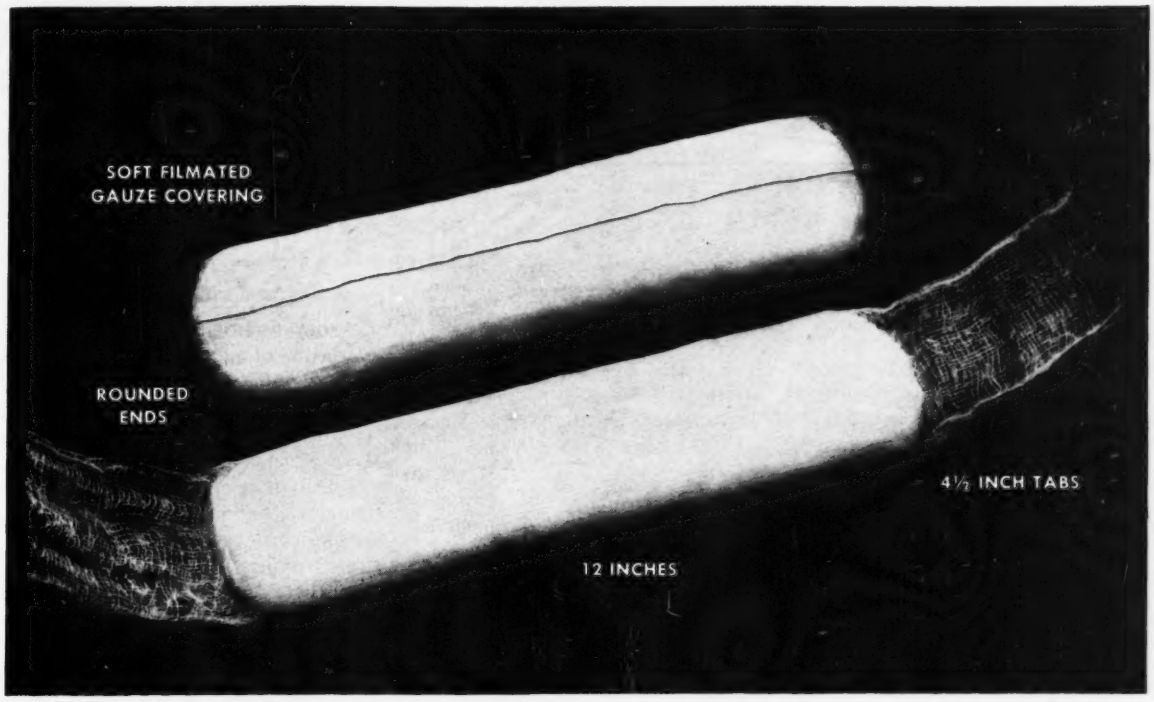
New Research Centre to be Opened at Hôtel-Dieu de Montréal

A new research department, soon to be opened at the Hôtel-Dieu de Montréal, will be of great interest to the medical profession. The department will conduct research into the causes and cures of high blood pressure and oedema. Also, lack of equilibrium between acids and bases in the human body will be studied.

The department will be headed by Dr. Jacques Genest, F.R.C.P. (C), F.A.C.P., who recently returned to Canada after a seven-year stay in the United States, where he worked at the Johns Hopkins Hospital and the Rockefeller Institute. Dr. Genest has just completed a survey of the current state of research and medical science in western European countries for the provincial government. At the Hôtel-Dieu he will carry on the work he began at the Rockefeller Institute. The research team will include three medical doctors as assistants, one chemist, two technicians, and a secretary.

The research centre is situated in the new de Bullion Wing, which was completed recently at the hospital. The department itself consists of a five-room laboratory, a 24-bed ward, an out-patient clinic, and a room to house animals used for experiments.

Furnished with all necessary equipment, the laboratories contain many instruments which are unique in the province. Among these is a machine used to fractionate certain hormones, which was purchased at a cost of $2,400. Another innovation is a $2,600 electrocardiograph which records electric currents generated by the heart, as well as heart murmurs and blood pressure in the veins. A room is included in the department where a desired temperature, between 40 and 70 degrees Fahrenheit, can be maintained for any length of time. This room is for the storage of precision instruments and the performance of sensitive analyses.—*Sister Allard.*



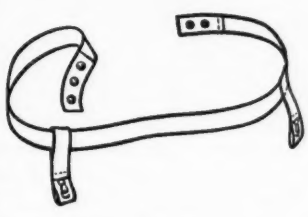
New post-partum NUPAK pads cut costs by half under actual tests

NUPAK PADS are specially designed for use during the first post-natal days. Their greater absorptive capacity and special 12 inch length result in increased economy and practicality.

Many hospitals have found that, because of Nupak's oversize, one pad can be used where two or more were formerly employed, cutting obstetrical department costs and saving nursing care hours.

CHECK THESE ADVANTAGES:

- Greater absorptive capacity
- Rounded ends
- 12 inch length with 4½ inch tabs
- Less changing time required
- Sealed gauze covering
- Cotton filmated gauze covering



SPECIAL MATERNITY BELT

designed for use in conjunction with Nupak pads.

- **Adjustable snap fastener** — eliminates stepping into belt. 4 areas of adjustment.
- **1 inch width,** for more comfort.
- **Metal catch** for affixing pad.
- **Launders readily** — stands up under numerous washings.

Johnson & Johnson
LIMITED MONTREAL

Provincial Notes

Nova Scotia

SYDNEY MINES. A new wing, which has been added to the Harbour View Hospital, was officially opened in December. The new structure will cost approximately $500,000 when completely equipped.

New Brunswick

NORTH HEAD. As a result of the 1952 hospital fair, the sum of $3,089.36 has been given to the Grand Manan Hospital by the Grand Manan Community Association. The amount is nearly double that raised and donated to the hospital in previous years.

* * * *

WOODSTOCK. Tenders have been called for the construction of a new $1,000,000, 80-bed hospital which will be built near the present hospital, the Fisher Memorial Hospital. The new structure will have space for 13 private and 15 semi-private rooms, as well as four public wards, with four beds each, an eight-bed paediatrics department, and a nursery. There will be two operating rooms, an x-ray department, laboratory, and an out-patient department. The building has been designed by the architectural firm of Govan, Ferguson, Lindsay and Associates, Toronto and it is expected that construction work will begin early this spring.

Quebec

MARIA. Work has begun on the construction of a new 75-bed hospital which will serve a section of Bonaventure county in the Gaspé Peninsula. It will be built on property near the present Bourg Hospital and will be under the direction of the Sisters of St. Paul de Chartres. It is expected that building costs will be approximately $450,000 and will be paid for by the provincial government.

MONTREAL. The new $3,000,000 wing to the Hôtel-Dieu de Montréal is now open to receive patients but will not be officially dedicated until February. The wing will be known as the de Bullion Pavilion, in honor of Madame Claude de Bullion, benefactress of Ville Marie's first hospital. Built of cut stone, the wing contains 200 beds, in addition to operating rooms, and special treatment departments.

Ontario

BARRIEFIELD. Tentative plans have been prepared for the construction of a new military hospital here. Estimated cost of the structure and equipment is $5,000,000.

* * * *

CAMPBELLFORD. It is expected that the new Campbellford Memorial Hospital, which is nearing completion, will be ready for occupancy shortly. Originally planned as a 38-bed institution, 20 more beds will be added in one wing of the ground floor for long-term patients.

* * * *

NEW LISKEARD. The new, $360,000 New Liskeard and District Hospital was officially opened by the Hon. MacKinnon Phillips, M.D., minister of health for Ontario, at the beginning of November. Built to replace the Lady Minto Hospital, which had served the community since 1907, the 40-bed structure is of red brick.

* * * *

OTTAWA. Work is progressing on the $3,500,000 extension program of the St. Vincent's Hospital for Incurables. A total of 512 beds will be available when the project is completed. The expansion comprises the addition of a fifth storey to the existing hospital and two new wings. Patients have already been moved into the fifth storey. One wing is scheduled for completion this summer and the second addition will be completed later. Provincial approval has been granted for the hospital to change its name to St. Vincent's Hospital for the Chronically Ill. Occupational therapy and physiotherapy departments will be set up at the hospital, as well as a rehabilitation centre.

* * * *

PORT ARTHUR. Plans for the construction of additional buildings at the Ontario Hospital here, which will cost more than $1,500,000, were announced recently by the Hon. F. S. Thomas, provincial minister of public works. Already nearing completion at the hospital is a building program which cost approximately $3,500,000. When this latest project is completed the hospital will have accommodation for 884 patients. Other building projects will be planned in the near future and it is expected that by 1955 the hospital will have accommodation for 1,200 patients and will have cost between seven and eight million dollars.

* * * *

PORT ARTHUR. Final plans for the construction of a 100-bed nurses' residence to the St. Joseph's Hospital have been drawn up by the architect A. E. Angus, Port Arthur. Demolition of one of the older residences is now underway and construction of the "T"-shaped building is expected to begin this spring.

* * * *

TORONTO. The city's board of control have decided to match, dollar for dollar, any grant which the province makes toward the completion of the new Mount Sinai Hospital. The city has given $379,666 to the hospital since 1946. Federal and provincial governments have granted equal amounts and the county of York has contributed $50,000.

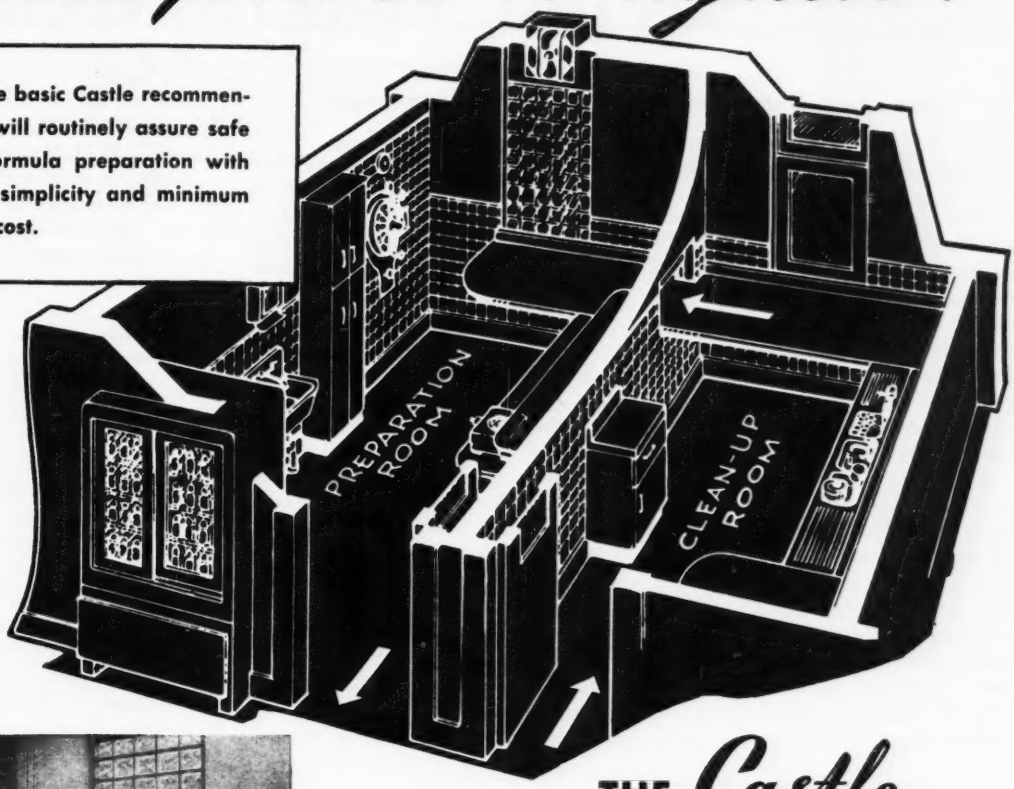
* * * *

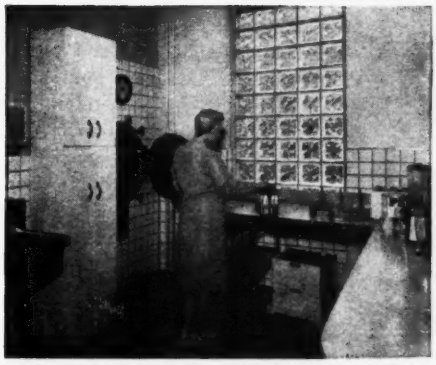
TORONTO. The first step toward the erection of a hospital to serve the Lake Shore and Queen Elizabeth areas was announced recently when an option on

(Concluded on page 82)

Castle proves it again!

. . . These basic Castle recommendations will routinely assure safe infant formula preparation with greatest simplicity and minimum per-unit cost.





Where practical, as in Castle's recent Genesee Hospital installation, windowed storage refrigeration facilities afford practical supervisory advantages and visitors are happily impressed.

THE *Castle* MILK FORMULA ROOM TECHNIC

- Provides for meticulous cleansing, rinsing and draining of bottles, nipples and accessories within the area designated as the receiving or clean-up section . . . time and cost are saved by terminal sterilization in the concluding process.

- In the preparation section of the Formula Laboratory, terminal heating of bottled and nippled formulas at 230°F. for 10 minutes is sufficient to produce formulas that are bacteriologically safe . . . terminal sterilization permits the use of single door autoclave construction which offers a triple saving in cost, installation and personnel. Its safety concentrates all steps in one simple process.

FACILITIES TO MEET EVERY VOLUME REQUIREMENT

Our experienced Planning Department is available to assist the hospital, the architect or hospital consultant without charge. Planning the Milk Formula Room is an important phase of our business and we welcome your invitation to suggest ways and means most economically practical.

Address your inquiry to **WILMOT CASTLE COMPANY**
1176 University Ave., Rochester 7, N. Y.

THE STEVENS COMPANIES — TORONTO, WINNIPEG, CALGARY, VANCOUVER — *Castle* — CASGRAIN & CHARBONNEAU, LTD., MONTREAL

◂ Health Care Plans ▸

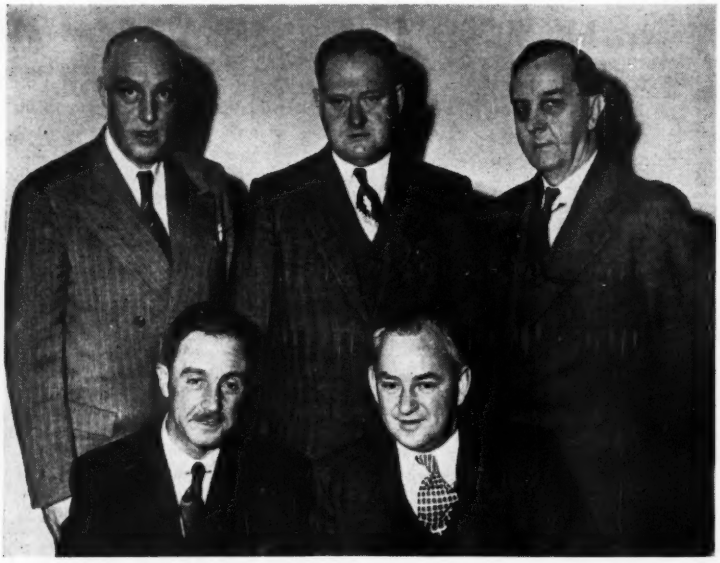
Canadian Blue Cross Chiefs Meet in Montreal

Trustees and executive directors of the five Canadian Blue Cross Plans met in Montreal on November 26, 27 and 28. They sought methods of establishing and continuing policies concerning the application of prepayment principles and procedures to coverage, regulations, statistics, and information, insofar as they are of a national character. Blue Cross plans now cover eight Canadian provinces and have a total membership of 3,000,000.

The meeting of the executive directors was under the chairmanship of Ruth Cook Wilson, executive director of Maritime Hospital Service Association, and chairman of the administrative section of the Canadian Council of Blue Cross Plans. Others present were: J. A. Monaghan, executive director of Alberta Blue Cross; E. Duncan Millican, executive director of Quebec Hospital Service Association; David W. Ogilvie, director of the Plan for Hospital Care of the Ontario Hospital Association; and Frank MacCharles, who became executive director of Manitoba Hospital Service Association, on Nov. 1, 1952. Mr. MacCharles was elected vice-chairman of the administrative section of the council, succeeding A. L. Crossin who has retired.

At this meeting, the administrative section of the Council received the reports of committee chairmen: H. J. DeLaney, Moncton, on hospital relations; R. P. H. Sprague, Winnipeg, on hospital claims; K. C. Cross, Toronto, on public relations; Leo Leblanc, Montreal, on enrolment; and H. W. Brown, Montreal, on office practice. In a brief summary of talks held, Miss Wilson said: "The Canadian Council of Blue Cross Plans is greatly encouraged, not only by the steady progress of each non-profit Blue Cross Plan but also by the fine spirit of co-operation in which problems of a mutual nature are discussed. There is no doubt that, in such an atmosphere of understanding, the work of the Council will contribute to the advancement of prepaid health care in Canada."

Summing up discussions and views as expressed at the meeting of the trustees, J. R. H. Robertson said: "We are looking to the future with increased confidence, as each year the foundation of the non-profit prepayment plans appears more secure".



Trustees of Blue Cross Plans are, standing left to right: Dr. D. R. Easton, board of trustees, Alberta Blue Cross Plan; Dr. W. Douglas Piercey, chairman of the executive committee, Ontario Hospital Association; and Dr. O. C. Trainor, chairman of the board, Manitoba Hospital Service Association. Seated, left to right: J. R. H. Robertson, chairman of the board, Quebec Hospital Service Association and president of the governing board of the Canadian Council of Blue Cross Plans; and Dr. Joseph A. McMillan, chairman of the board, Maritime Hospital Service Association.

* * * *

Health Information Pamphlets Available Through Blue Cross Commission

Since 1946, the Blue Cross Commission of the American Hospital Association has been publishing, as part of its health education program, a quarterly health digest, *Blue Print for Health*, that is distributed to plan group leaders and members, as well as to doctors, dentists, hospitals, schools, public libraries, et cetera.

The first of a series of pamphlets containing reprints of articles appearing in *Blue Print for Health*, and designated as the most helpful in a recent readership survey, are being distributed. Included in the series are: "Unseen Magic in our Food", and "A Full Plate—but are you well nourished", by Pearl Lewis, B.S.; "Operation Hospital", by Evelyn S. Ringold; "Migraine", by Noah D. Fabricant, M.D.; and "How to keep from hating people", by K. C. Ingram. Additional titles will be added to the Health Information Pamphlet series from time to time.

* * * *

Blue Cross payments to hospitals in Canada for care of Blue Cross members in 1951 amounted to $29,952,345 — 90.79 per cent of total earned subscription income. For the first six months of 1952 Blue Cross paid Canadian hospitals $18,258,120 — 90.64 per cent of total earned subscription income.—"*Hospital Briefs*"

No physician, in so far as he is a physician, considers his own good in what he prescribes, but the good of his patient; for the true physician is also a ruler having the human body as a subject and is not a mere money-maker.—*Plato*

Now *at your service..*

XYLOCAINE®

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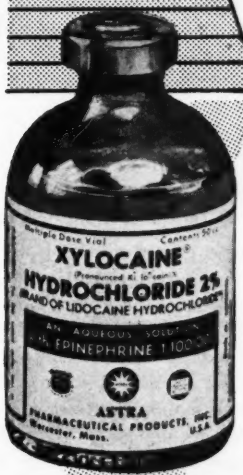
HYDROCHLORIDE

ASTRA

(Brand of lidocaine hydrochloride*)

AN AQUEOUS SOLUTION



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NEW local anesthetic

QUICK-ACTING

POTENT

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WELL-TOLERATED

A potent, short-acting local anesthetic, producing on injection, a more prompt, intense and extensive anesthesia than equal concentrations of procaine hydrochloride. Useful and effective either with or without epinephrine, it has been described (1) as the most promising of the new local anesthetics, approaching in efficiency the nerve blocking properties of piperocaine, and in toxicity, the advantages of safety presented by procaine.

(1) Hanson, I. R. and Hingson, R. A., *Current Researches in Anesthesia and Analgesia,* 29:136 (May-June) 1950.

ASTRA PHARMACEUTICAL PRODUCTS, INC.
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AUTHORIZED DISTRIBUTORS FOR CANADA

THE Stevens COMPANIES

TORONTO CALGARY
WINNIPEG VANCOUVER

Dispensed in 50 cc and 20 cc multiple-dose vials containing 0.5%, 1% or 2% solution. All solutions available without epinephrine and with epinephrine 1:100,000. 2% solution also supplied with epinephrine 1:50,000.

*U. S. Pat. No. 2,441,498

With the Auxiliaries

Reports by Branch Auxiliaries of the Montreal General Hospital

The annual meeting of the town of Mount Royal branch of the women's auxiliary to the Montreal General Hospital was held recently. It was reported that the auxiliary had a total membership of 272. More than six regular and 10 reserve volunteers had put in 396 hours of work at the snack bar. In addition, two librarians had given 234 hours of voluntary work, and a member of the executive had given 288 hours in one of the clinics. During the year there were two money-raising events; a bridge in February at which $135 was raised; and a tea and knick-knack sale in June, which netted $192.-74. The branch took in $1,169.59 throughout the year. Of this sum $649 was transferred to the central committee and $85 was paid out for material to be used to make articles for the auxiliary's shop. At the end of the year, an additional $100 was paid to the central committee.

The Outremont branch of the women's auxiliary to the Montreal General Hospital also held their annual meeting recently. The treasurer reported that $1,002 had been given to the central committee by their branch. Some 2,262 articles were completed by the sewing committee for the hospital. Ditty bags were made and filled for the patients at Christmas time.

* * * *

Newly-formed Auxiliary at Dryden, Ontario

Some 350 members joined the newly-formed ladies auxiliary to the Dryden District General Hospital, Dryden, Ontario, during a membership drive in May. In the short time which the auxiliary has been functioning, many projects have been undertaken. A rag drive brought in $200 and proceeds from a tag day netted $350. At a food drive in October, approximately $2,000 in food, canned goods, and cash, were collected. When a new theatre opened recently in Dryden, members of the auxiliary sold 587 tickets at $1 each, for the opening night. The money was donated to the new hospital's building fund. In the past few months, the auxiliary has contributed $200 for the purchase of linens, $60 for dishes, $160 for an automatic toaster, and $50 for a new medical cart. A new washing machine was also donated to the nurses' residence.

* * * *

Report Presented by Auxiliary to St. Joseph's Hospital, Saint John, N.B.

The women's auxiliary to the St. Joseph's Hospital, Saint John, N.B., has a membership of 575. The annual Maytime Tea, held during the past year, netted over $1,000. This amount, together wth funds from bridge parties and membership dues, enabled the auxiliary to present a cheque for $1,400 to the hospital. Among the items purchased have been an electrocardiograph, laboratory equipment, a stretcher, wheelchairs, hospital linen and furnishings for the wards. At Christmas time, the auxiliary provides treats for needy patients and the children in the hospital. Reading material is also supplied to the patients. A prize of $10 is given annually to the member of the nurses' graduating class who stands highest in obstetrical nursing. Each autumn, jams and jellies are collected for the hospital. This fall, over 1,000 jars were collected.

* * * *

Auxiliary at St. Catharines, Ont. Presents Annual Report

The annual report, for the year ending August 31st, 1952, was presented recently to members of the ladies auxiliary to the Hotel Dieu Hospital, St. Catharines, Ont. The treasurer reported that total receipts for the year were $7,767.83 which, with a balance of $1,805.32 from August, 31st, 1951, made up total assets of $9,573.15. Disbursements for the year were $8,781.32, leaving a balance of $791.73. Expenditures were $5,800 for an accounting machine; $400 for a public address system; $230.57 for an addressograph machine; $200 for drapes for the nurses' residence; and $487.77 was used to purchase equipment for use by the auxiliary. During the past year, 115 new members have joined the auxiliary, bringing the total membership to 637. Two life memberships were awarded.

* * * *

Chrysanthemum Display Highlight of Tea

An attractive display of chrysanthemums proved to be a highlight of a recent tea, sponsored by the ladies' senior auxiliary to the Penticton Hospital, Penticton, B.C. Many of the display flowers were sold at the conclusion of the tea. A special appeal for woollen materials, which would be suitable for use as hot fomentations in the treatment of poliomyelitis, was made and contributions brought to the tea filled a large portion of the checking room.

* * * *

New Gift Shop Opened at Toronto Western Hospital

A new gift shop has been opened at the Toronto Western Hospital, under the auspices of the women's board. For some 57 years the women's board has been working for the hospital. The gift shop, one of the latest projects to be undertaken, has been set up to serve the patients and staff of the hospital. Standard stock will be kept on hand and sold at prices in line with regular shops of this type. It will be staffed by 90 volunteers working in shifts.

* * * *

Auxiliary Donates $10,000 to Metropolitan Hospital, Windsor, Ont.

A cheque for $10,000 was presented to the board of governors of the Metropolitan Hospital, Windsor, Ont., by the women's auxiliary. The money will be used to furnish and equip one semi-private room and a four-bed ward, on each of the first three floors of the new wing. This sum will also provide for the purchase of some equipment for the paediatric department on the fourth floor. During the past year the auxiliary has spent over $5,000 on supplies for the hospital. Members are now busy planning for an antique show, to be held this spring.

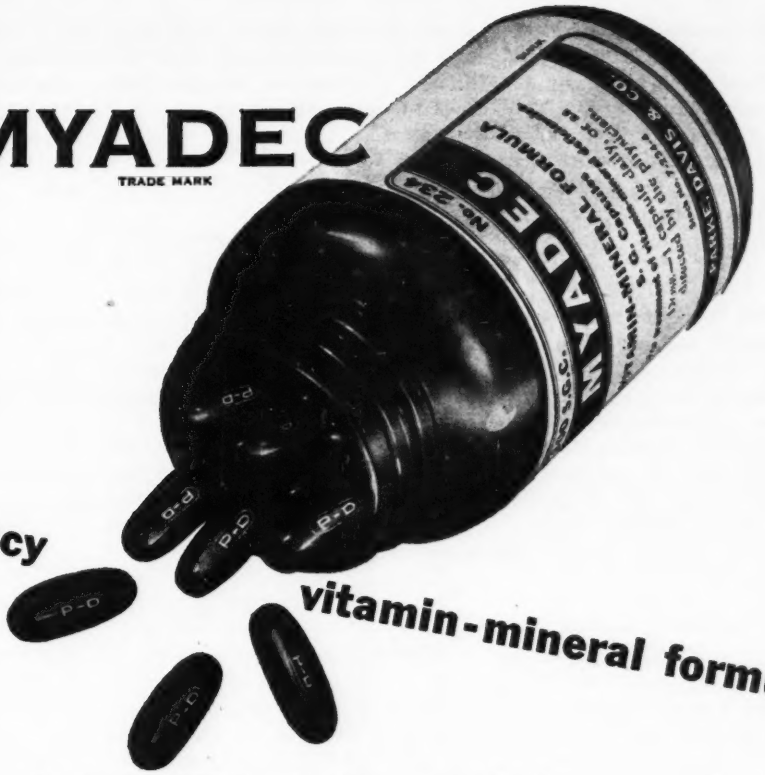
* * * *

Auxiliary Donates Oxygen Tent

An oxygen tent, which cost approximately $766, and three chairs for pa-

MYADEC

TRADE MARK



high potency vitamin-mineral formula

Physicians are welcoming MYADEC Capsules, the new comprehensive vitamin-mineral formula that helps prevent or correct nutritive failure. Nutritional balance plus more effective utilization of vital nutrients is provided by therapeutic potencies of 9 important vitamins often found lacking in the daily dietary, and 11 essential minerals and trace elements required for metabolic function.

Equally welcome to the patient, is the convenience of securing adequate nutritional support in one capsule, as well as MYADEC's reasonable cost – encouraging acceptance of the continued treatment often prescribed.

The Parke-Davis professional service representative who calls at your store will be glad to furnish you with detailed information concerning this new comprehensive nutritional adjunct.

EACH MYADEC CAPSULE CONTAINS

vitamins		minerals	
Vitamin B_{12} Crystalline	5 mcg.	Iodine	0.15 mg.
Riboflavin (Vitamin B_2)	10 mg.	Manganese	1.0 mg.
Vitamin B_6 (Pyridoxine Hydrochloride)	2 mg.	Cobalt	0.1 mg.
Vitamin B_1 Mononitrate	10 mg.	Potassium	5.0 mg.
Niacinamide	100 mg.	Molybdenum	0.2 mg.
Vitamin C (Ascorbic Acid)	150 mg.	Iron	15.0 mg.
Vitamin A	25,000 Int. units	Copper	1.0 mg.
Vitamin D	1,000 Int. units	Zinc	1.5 mg.
Vitamin E	10 I.U.	Magnesium	6.0 mg.
		Calcium	105.0 mg.
		Phosphorous	80.0 mg.

MYADEC Capsules are supplied in bottles of 50 and 100.

MEDICAMENTA VERA

Parke, Davis & Company, Ltd.

WALKERVILLE, ONTARIO

tients in the convalescent annex, were presented to the Saint John General Hospital, Saint John, N.B., by the women's hospital aid. "Jelly Day" was held in November and the auxiliary received many donations which were distributed between the General and Tuberculosis hospitals.

* * * *

Auxiliary to Aid New Hospital

The women's hospital aid society, which has a long record of service to the Galt General Hospital, Galt, Ont., will continue its good work by assisting the new South Waterloo Memorial Hospital. Recently, the auxiliary donated $1,600 to the new hospital to be used to equip a four-bed ward.

* * * *

Violet Tea Held by Auxiliary

Something novel in the way of tea parties took place in the cafeteria of the Sudbury General Hospital, Sudbury, Ont., when the women's auxiliary entertained at an African Violet Tea. There were about 57 varieties of blooms among the many plants, which were sold very quickly. A bake table also brought in substantial receipts which helped to make this new venture a big success.

* * * *

Auxiliary Aids Hospital at Red Deer, Alta.

At the first fall meeting of the auxiliary to the Red Deer Municipal Hospital, Red Deer, Alta., the matron of the hospital was presented with a cheque for $600 which will be used to provide furniture for the waiting room in the new wing of the hospital. In honour of the first baby born in the new wing, the auxiliary had presented the mother with a layette and a corsage, and the father received the traditional cigar.

* * * *

Active Auxiliary in Port Arthur, Ont.

At a recent meeting of the auxiliary to the Port Arthur General Hospital, Port Arthur, Ont., it was reported that the sum of $1,238.74 had been realized at a garden party. A membership drive was also very successful. The auxiliary voted a sum of $500 to the hospital to be used for linen and $250 to the school of nursing. It was also decided to purchase three industrial toasters at an approximate cost of $108 each.

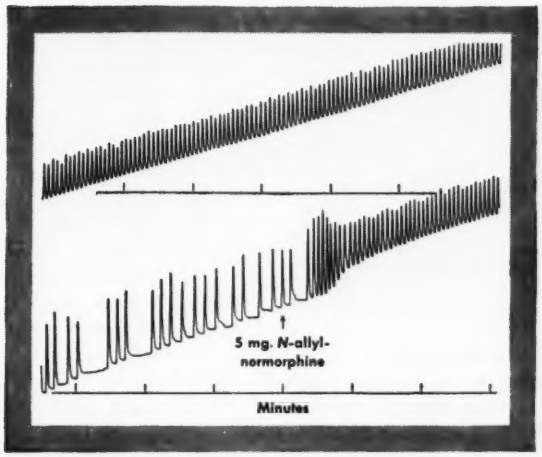
* * * *

Bazaar Nets More Than $2,219

More than $2,219 was cleared at a hospital bazaar, held by the women's auxiliary to the Memorial Hospital, Perth, Ont. It was decided that bonds would be purchased with some of the money and the rest would be used as working capital. Plans are being made for the annual January Bridge Night, to be held at the end of this month.

Living and moving as we do in a world of gadgets, we need to remember that truth, loyalty, courage, and faith are the realities that set men apart as creatures that live in the fullest sense, and these come only to people who seek them.—*Royal Bank of Canada Monthly Letter.*

Announcing a New and Specific Narcotic Antagonist—



Effect of NALLINE *on respiratory depression caused by 57 milligrams of morphine.*[1]

potent and well-tolerated

NALLINE is a specific antidote for poisoning following accidental overdosage with morphine and its derivatives, as well as meperidine and methadone.

This new product, the Merck brand of *N*-Allylnormorphine, rapidly reverses respiratory depression. The respiratory minute volume promptly increases and the rate increases two- or threefold.

A recent study[2] of 270 parturient women indicates that NALLINE may be of value in obstetrics. Onset of breathing occurred significantly sooner in infants from mothers (sedated with meperidine) who were given NALLINE 10 minutes prior to delivery.

Literature available

[1]Eckenhoff, J. E., Elder, J. D., and King, B. D., *Am. J. Med. Scs.* 223:191, February 1952. [2]Eckenhoff, J. E., Hoffman, G. L., and Dripps, R. D., Annual Meeting of the American Society of Anesthesiologists, Washington, D. C., Nov. 8, 1951.

SUPPLIED:
Solution of NALLINE Hydrochloride in 2-cc. ampuls containing 10 mg. of active ingredient, 5 mg./cc.

NALLINE comes within the scope of the Opium and Narcotic Drug Act and regulations made thereunder.

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Research and Production for the Nation's Health

MERCK & CO. LIMITED
Manufacturing Chemists
MONTREAL · TORONTO · VANCOUVER · VALLEYFIELD

Hospital Bed Needs

(Continued from page 35)

for capacity loads somewhat under peak demand. A well-planned hospital with a flexible room arrangement can operate with an average occupancy up to 80 or 85 per cent and still handle the peak demands very satisfactorily.

Unnecessary Use

It must be apparent to all that a certain proportion of our beds are occupied unnecessarily. This situation has not been helped by the development of the various prepayment plans, for the removal of the financial barrier has led to some abuse of the benefits, notably by unnecessary admissions, unnecessary prolonging of the stay, and unnecessary use of diagnostic and treatment procedures. In a recent article on "The Excessive Use of Blue Cross Benefits"* Dr. Kenneth B. Babcock of Detroit reviews some of these abuses. These include admitting patients to hospital for diagnosis only; complete work-up done after patients are admitted rather than before admission; using the hospital for procedures that can be performed at home or in doctors' offices; delayed test reports and delayed discharge of patients.

In 1951, a committee of five staff physicians at Grace Hospital, Detroit, reviewed 1,276 cases admitted during one month to that hospital. They found, among the private cases, 16 cases (or 165 hospital days) that did not require hospitalization for any apparent reason; 60 patients (560 days) had diagnostic work done that could have been done in offices or as out-patients: 16 (or 393 days) were in for x-ray therapy and physical therapy only; 24 took up 133 days in unnecessarily long pre-operative preparation and 24 took up 167 days of apparently unnecessarily long post-operative stay; 12 patients had 155 apparently unnecessary days for medical care; some came in under false diagnosis of acute illness in order to gain admission for a check-up.

For the private cases there were 1,700 days of apparently unnecessary hospital care. On the staff or public side there were comparable abuses. Pre-operative stay prior to surgery was much longer. X-rays, laboratory work and other procedures were repeated.

The committee, after studying all of the charts for the month, made the following recommendations:

1. Diagnostic procedures not requiring hospitalization should be done in the doctor's office, private laboratories, or out-patient department. It was recognized by the committee that insurance benefits play a large part in the misuse of hospital beds. A change in this policy would be desirable.
2. We recommend that, whenever possible, physical and x-ray therapy cases be treated as out-patients and not as in-cases. The same recommendation holds true for ambulatory orthopaedic cases.
3. It is recommended that individual physicians endeavour to keep the pre-operative and post-operative stay to a minimum and also keep the stay of the medical patient, in the hospital, to a minimum.
4. We recommend that more professional honesty be practised in the use of emergency diagnosis for the purpose of getting a patient admitted.
5. That the staff and clinic cases have consultations, x-rays, and laboratory studies, prior to admittance. We also recommend that these cases be boarded when ready for surgery and not put off for several days.

Future Changes

In assessing our bed needs we should consider certain changes that may come in the not-too-distant future.

One of these may be the development of supervised home care by the hospital after discharge. That is too big a topic to permit elaboration here but experiments have proved its value, as in Syracuse, in New York City, and now in Montreal. Hospitalization agencies, be they voluntary or governmental, may find it cheaper to pay for this supervised home care than to keep the patient in hospital. It might pay Blue Cross to look into this possibility as an economy as well as a service.

On the other hand, the Commission on Hospital Care in the United States anticipates the day when sanatoria will disappear and the little tuberculosis remaining will be treated in general hospitals. The increasing use of streptomycin and of lung and chest surgery, coupled with the falling incidence rate, gives point to this statement.

There is a feeling, too, that more of our mental cases will be treated in general hospitals in the future. Certainly we are getting more psychiatric units and they are doing good work.

Need for Long-Stay Beds

A particular need is for more beds for the long-stay patient. The national increase in this five-year period of 4,819 beds is a step in the right direction; but the total in 1953 of 10,819 is not enough for 14,000,000 people. Ontario had 2,030 beds in 1948 and will have 3,160 beds in 1953. But in 1953 the survey reveals that there should be 6,351 beds in use. Obviously an early major development in the hospital field should be an all-out program for the care of long-stay patients.

Too Many Hospitals?

Not only must we weigh carefully the bed need of an area, but some policy is essential as to whether they are to be centralized in a few communities or spread out over many. The government grants have greatly stimulated the growth of quite small hospitals; many of these have been needed not only for local obstetrics and emergencies but to hold the local physician. Others, however, have been of questionable need, considering all factors, and have been instrumental in preventing any hospital in the area from having enough patronage to finance specialized equipment and technicians.

There are many arguments on either side, of course, and generalizations are not advisable. Obviously the Department of Health has some responsibility here.

It can be said that modern techniques require a considerable measure of centralization and that present-day roads, good cars, and winter snow-ploughing, have overcome the need of a tiny hospital in every town.

Personally I would rather drive 25 miles to a properly staffed and equipped hospital than drive 5 miles to a smaller one without proper equipment and trained staff and quite unable to cope with anything requiring more than simple procedures.

The isolated country doctor, however, does require some beds for emergencies and obstetrics and the program, favoured in the West, of providing a few beds in a nursing station for his use would seem to be a good way of bridging this gap.

Conclusion

In conclusion, the main point which I wish to leave with you is that we should use discretion in determing how many beds we need. We need more beds, of course—many more beds now and still more in the future. The provision of adequate hospital facilities is one of the finest investments which communities and public-spirited citizens could possibly make. Moreover, if

(Concluded on page 72)

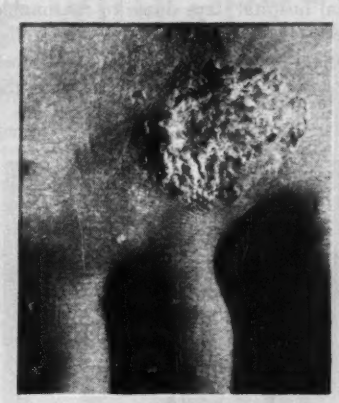
*Babcock, Kenneth B., M.D.: *"The Excessive Use of Blue Cross Benefits,"* Hospitals, July, 1952, Vol. 26, p. 49.*

Record it

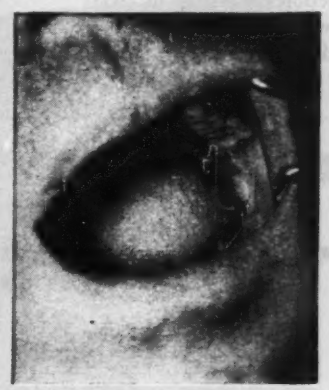
...with photographs in black and white, or color

HOSPITALS and clinics, physicians and surgeons, more and more of them, are *making photography routine*. As a result, case histories are more accurate, more comprehensive, less bulky; files are full of "live" material for teaching, diagnosis, research, reference.

Melanoblastoma, scleral extension glaucoma.



Infectious eczematoid dermatitis.



Intraoral pemphigus.

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Hospital Bed Needs

(Concluded from page 70)

we need them now, we should proceed with our planning, for the record over the years gives us little, if any, hope that costs will come down. Many Boards wish now that they had built several years ago; in 1963 we shall probably sigh and long for those low construction costs back in 1953!

But we should face the fact that this demand for bed accommodation can get out of hand—may have already got out of hand in some ways. The public, the doctors and the hospitals themselves must work together to keep down the cost of sickness. It does not help the over-all picture much if, in spreading the cost over the many rather than the few by insurance plans, we take the brakes off the demand for more beds. Collectively we can keep total hospital days down to reasonable figures; if we do not exercise long-range thinking and each one of us does not develop a social conscience, the voluntary system will break down and all that will save our taxation for hospital care from getting out of sight will be the utter inability to find adequate nursing and technical personnel to permit new wings to be opened.

Catholic Hospitals of Manitoba Elect New Officers

New officers of the Catholic Hospital Conference of Manitoba are as follows:

President: Sister St. Odilon, Misericordia Hospital, Winnipeg.

Vice-president: Sister Gertrude Jarbeau, St. Boniface Hospital, St. Boniface.

Secretary-treasurer: Sister St. Veronica, Misericordia Hospital, Winnipeg.

Directors: Sister M. Berthe Dorais, St. Boniface Hospital, St. Boniface; Sister Ste. Bertha, Misericordia Hospital, Winnipeg; Sister Larocque, Flin Flon Hospital, Flin Flon; Sister Angela, Johnson Memorial Hospital, Gimli; Sister M. Honora, St. Joseph's Hospital, Winnipeg; and Sister M. Jeanette, St. Joseph's Hospital, Winnipeg.

Food Service Contest Open to Canadian Hospitals

Institutions Magazine has announced the beginning of its 7th annual food service contest, which is open to various institutions in the United States and Canada. Hospitals are eligible to enter the contest under the hospital classification which includes four categories, based on the number of meals served each month. These categories are: 1—more than 75,000; 2—from 25,001 to 75,000; 3—from 10,001 to 25,000; and 4—less than 10,000. Full particulars concerning the contest can be obtained by writing to the Food Service Contest Editor, Institutions Magazine, 1801 Prairie Ave., Chicago 16, Ill.

In 1950, St. Joseph's Hospital, Victoria, B.C., won an award in this contest (see *The Canadian Hospital*, Aug., 1952, page 44).

Culture

Culture is not something you put on like a ready-made suit of clothes but a nourishment you absorb to build up your personality. It is not an ornament used to decorate a phrase, still less to show off your knowledge, but a means painfully acquired to enrich the soul.—*Somerset Maugham*

Minute May Mean Life, Hotel Dieu Saves Time with Speedy Intercom

By TRACY LUDINGTON

Those were the words Sister Allard, superior of the Hotel Dieu Hospital, used yesterday to describe the intricate interdepartmental and patient-nurse communications system in the hospital's new wing which opens in February.

So delicate is this communications system that a nurse at a master control board has but to flip a switch to hear even the breathing of a patient in any room. Then she can judge whether the patient—awake or asleep—has changed in condition since last charted.

The system is a far cry from the early mercy practices of Jeanne Mance and Madame de Bullion, after whom the new pavilion is named.

The building is eight storeys high. Three storeys are reserved for patients in semi-private rooms. The new wing adds 220 beds to bring the hospital's capacity to 750. Cost is set at $3,500,000 and work began in December, 1950.

Inside the glass and chromium doors on the ground floor is the doctors' registration panel. When a doctor enters he signals his arrival. If there are messages for him, they are given to him through a loudspeaker at the side of the board.

The intercommunication system, most complete of any hospital in the Dominion, also has a general appeal system, patient-nurse hook-up, diet kitchen communication with central kitchens, operating room communications, and special systems to the X-ray, bacteriology, pathology and therapy departments.

On the fourth floor are 12 operating rooms, two of which are surmounted by specially constructed observation rooms seating 42 students each. Before each student is a screen on which the entire technique of an operation can be seen.

While the building will not be [illegible]y furnished until Febru[illegible] are some patients on the [illegible] in semi-private rooms. [illegible]

work in modern surroundings

developing units, the first in Canada and the second on the continent. Duration of the photo is controlled by an electric eye.

The 12 new operating rooms in the Madame de Bullion wing will be designated for different types of operations, eye, ear, nose, throat, etc.

Since gases used as antesthetics are explosive, floors are specially treated to avoid static electricity causing sparks and all electrical apparatus is specially constructed.

Each group of operating rooms has a separate sterilizing room. Recovery rooms, attached to each group of operating rooms handle [illegible]

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The Hotel Dieu of Montreal—one of Canada's outstanding hospitals—is equipped entirely with Electro-Vox systems of intercommunication, conceived and manufactured and installed by Electro-Vox Inc., Montreal.

THE CANADIAN HOSPITAL

The Canadian Hospital is published monthly by the Canadian Hospital Council as its official journal devoted to the hospital field across Canada.

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General Hospital at Cornwall, Ont. To Set Up Pathological Laboratory

A pathological laboratory is to be established at the Cornwall General Hospital, Cornwall, Ontario. The laboratory, which is being set up with the assistance of the provincial and federal departments of health, will fill a long-felt need in the area. At the present time, specimens have to be sent to Kingston, Montreal, or other centres for analysis. The laboratory will be subsidized by an annual grant from the Ontario Department of Health for carrying on public health diagnostic work. It will be the sixth of its type in the province. The others are at Peterborough, St. Catharines, Kitchener, Belleville and Stratford.

Dr. W. J. Shannon, of South Shields, England, consultant pathologist at the South Shields group hospitals, has been appointed pathologist. It is hoped that the laboratory will be in operation shortly.

New Address

The Catholic Hospital Council of Canada has changed its address to 1 Stewart Street, Ottawa, Canada.

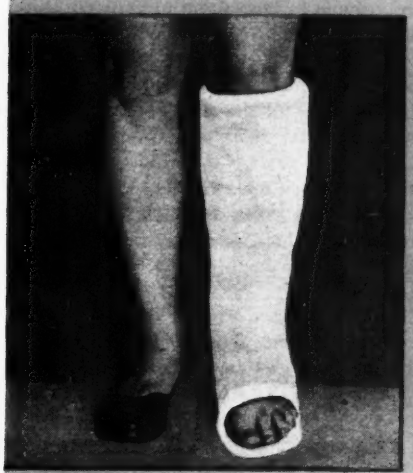
Melmac*

Orthopedic Composition

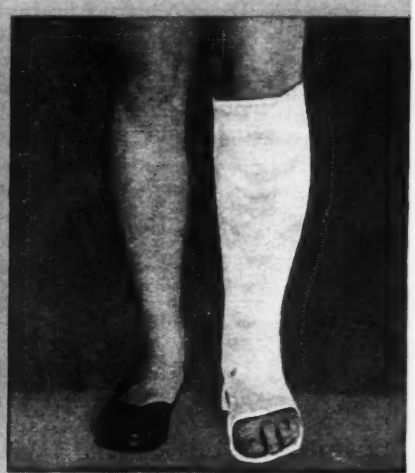
for lighter, thinner, stronger casts

Davis & Geck's Melmac Orthopedic Composition is a melamine resin,† a new powder with catalyst which *doctors* add to the water in which *they* wet plaster bandages. With Melmac Orthopedic Composition, *doctors* need only *half the usual number of plaster of Paris bandages.* Melmac has been proven by extensive clinical trials.[1-3]

Greater comfort for patients



Cast A—ordinary plaster of Paris



Cast B, *plaster fortified with Melmac,* is half thickness of cast A and weighs less

6 great advantages of casts made with Melmac Orthopedic Composition

1. *Four times the early strength* and over twice the dry strength of ordinary plaster of Paris casts.
2. *Lighter, thinner and stronger casts* provide added comfort and support.
3. *Water and urine resistant.* Does not disintegrate even after several days soaking.
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Supplied: In cartons of 3.65 lb. containing six cans of 9.74 oz. (276 Gm.) each; available through surgical supply dealers handling D & G products.

Davis & Geck, Inc.

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Sutures and other surgical specialties

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Use of Melmac requires no new technique

To use bandages and splints wetted with Melmac solution, no new technique for applying casts need be learned. Plaster rolls or splints are soaked in the Melmac solution in the usual manner, the excess solution is pressed out, and the cast applied with the same technique as with ordinary plaster bandages and splints.

Note:

Cobey,[3] reports not one person allergic to Melmac in applying 1000 casts.

references:

1. A. W. Spittler, Col., (M.C.), U.S.A., J. J. Brennan, Lt. Col., (M.C.), U.S.A., J. W. Payne, Capt., U.S.A.F. (M.C.), American Academy of Orthopedic Surgeons, Jan. 26-31, 1952, Chicago, Illinois.
2. M. C. Cobey, M.D., F.A.C.S., Professor of Orthopedic Surgery, Georgetown University and Senior Attending Orthopedic Surgeon, Children's Hospital, Washington, D.C., The American Surgeon, Vol. XVIII, No. 4, April, 1952, pp. 413, 415.
3. M. C. Cobey, M.D., F.A.C.S., Washington, D.C., private communication.

Davis & Geck manufactures a complete line of surgical sutures. Diameter for diameter D&G Surgical Gut is the strongest available.

Why are Ethics Required of a Profession ?

(The following is an article, by W. A. Mackintosh, Principal, Queen's University, Kingston, Ontario, which appeared in "Ontario Medical Review", September, 1952).*

Historically, a profession is distinguished from an occupation or employment by the extent of learning required for its proper practice. Traditionally, the professions are learned professions. Members of a profession must be skilled but there is no way of saying whether the skill of the surgeon is greater than the skill of the contortionist. It may not even be so rare. We can say only that the skill of the surgeon is more frequently and urgently needed. The physician, the surgeon, or the barrister, is not distinguished from the mechanic, the air pilot, or the jockey by his skill but by the extent of the knowledge and experience within which his skill operates.

*See page 90.

The distinction between the learned and the unlearned is an ancient one. It was the distinction between the clergy and the laity which at times was not much more than the difference between the literate and the illiterate. Historically, learning carried with it privileges which were denied to the unlettered. "Benefit of clergy" was extended to any clerk, which at times meant anyone who could write.

Professions as bodies of learned men were early given, or assumed themselves, rights of establishing standards of entrance to and of conduct in the profession. The early practice by which they were to a degree above the law has been long since discarded but to an important degree privileges have been maintained. Today, of course, a professional man is subject to the law as an ordinary citizen but he is also subject to a variety of special laws bearing on the practice of his profession. The earlier view that the laity was not fit to pronounce on standards within a profession has been maintained in leaving to various professions the right, within the law, to determine conditions of entrance to the profession and to decide the standards of conduct of those who wish to remain in good standing in the profession.

The degree to which a profession is governed by its professional ethics represents the respect paid by the laity to the learning of the profession. Professional ethics are, of course, also related in most cases to the intimate personal relationship established between the practitioner and his client, patient, parishioner, or pupil. A code of ethics, interpreted by practitioners, can be much more flexible and pervasive than a code of law. A code of ethics is or should be something to be lived up to. A legal enactment too often marks the limit to which a citizen can go in a wrong direction without incurring the penalties of the law. To be within the law is far short of measuring up to a code of professional ethics.

History makes quite clear that professions, which are lax in their professional ethics, soon lose their privileges and are subjected, if important

enough, to close legal regulation. Quite aside from any moral consideration then, professional ethics are to be safeguarded assiduously. It is not merely that they may become nominal or of influence only spasmodically. They may degenerate to mere regulation of trade practices. Trades also regulate admittance. There is scarcely any mercenary pursuit which does not christen its restrictive practices as ethics. It is only if professional ethics are maintained rigorously at a high standard and are evidently the ethics of a learned profession that the privileges of the profession will persist in a modern society.

Chest X-rays Prove Popular Among People Attending C.N.E.

According to the Canadian Tuberculosis Association "Bulletin", Sept.-Oct., 1952, the National Sanatorium Association in Ontario has been giving chest x-rays at the Canadian National Exhibition in Toronto ever since 1947. This has become such a popular service that they now have a large number of people sayng, "Oh, I'll get my yearly x-ray at the Ex." Such are the fruits of a well organized and continuous program of health education.

The Canadian National Exhibition attracts people from all over the world. Nearly every year there are some persons from India, France, and the South American countries. If any of them are unfortunate enough to have a dubious plate the miniature film is sent to them with the suggestion that they consult a doctor. The National Sanatorum Association makes no other attempt at follow-up on people who reside outside Ontario.

A progress report over the years reveals the following.

Year	*X-rays*	*Active TB*
1947	13,277	3
1948	24,192	27
1949	23,534	10
1950	29,744	17
1951	29,988	19
1952	28,641	—
	149,376	76

Among all the strange things men have forgotten, the most universal and catastrophic lapse of memory is that by which they have forgotten that they are living on a star. — *G. K. Chesterton*

New Regulations for Enriched Bread

On January 1st, 1953, it became legal to market two new kinds of bread throughout Canada. The Food and Drug Regulations read as follows:

B.13.022. Enriched Bread. Enriched White Bread shall be bread baked from a dough in which enriched flour is the only flour used and shall contain not less than two per cent by weight of the flour used as skim milk solids and shall contain in each pound not less than 1.1 milligrams and not more than 2.4 milligrams of thiamine, not less than 0.8 milligrams and not more than 1.8 milligrams of riboflavin, not less than 10.0 milligrams and not more than 15.0 milligrams of niacin or niacinamide, and not less than 8.0 milligrams and not more than 12.5 milligrams of iron.

B.13.023. Vitamin B White Bread (Canada Approved) shall be baked from a dough in which Vitamin B White Flour (Canada Approved) is the only flour used and shall contain not less than: (a) four per cent, of the weight of the flour, of skim milk solids; and (b) in one pound of the bread 0.54 milligrams of thiamine together with the attendant members of the vitamin B complex.

B.13.024. Vitamin B White Bread (Canada Approved) in the making of which enriched vitamin B white flour is the only flour used, shall be designated "Enriched Vitamin B White Bread".

Canadian nutritionists may not realize that the maximum and minimum values for thiamine and riboflavin have been set at higher values than those prevailing for Enriched White Bread in the United States. This was necessary for two reasons: (1) Vitamin B White Flour (Canada Approved) contains more of the nutrients than ordinary white flour, when both are "enriched" at the same rate, they reach different levels; (2) skim milk powder is required at the rate of two per cent in ordinary Enriched White Bread and at the rate of four per cent in Enriched Vitamin B White Bread. Ordinary white bread, presently obtainable in Canada, therefore will continue to be poorest in these nutrients; next up the ladder will be Vitamin B White Bread (Canada Approved) as at present; next will be Enriched White Bread and the highest food value including benefits known and unknown from longer extraction, would come from Enriched Vitamin B White Bread. The average analyses of such breads will not be known until some time after they have been on the market.

It must be remembered that "Enriched" breads are not being introduced into Canada (except Newfoundland) in response to any nutritional demands or needs. If a person is eating a variety of foods as indicated in *Canada's Food Rules*, he need not worry about these four nutrients and can choose any of the many appetizing bread products that are available. The use of "enriched" flours or bread is more in the nature of insurance against a possible deficiency that might occur rather than making good any deficiencies that are known to exist.—*Reprinted from "Canadian Nutrition Notes," November, 1952.*

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RESTAURANT RANGE. Model 183GG; Two ovens, griddle and broiler, open top or combination hot top.

RESTAURANT RANGE. Model 182: One oven, griddle and broiler, open top or combination hot top sections.

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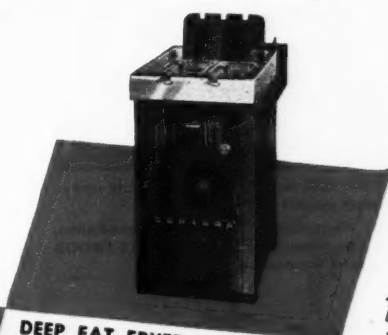

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Medical Practitioner

(Concluded from page 41)

possible, in order to give a practical education in the problems of the institution to all concerned. Wherever and whenever possible hold your meetings with the medical staff at regular intervals during the daytime. The medical man you will want on your staff is usually quite busy and has little enough opportunity to spend evenings with his family, with his journals or books, or for personal entertainment. Keep all the medical men, using your hospital, informed of your thinking, plans, hopes, and desires for the institution. By this means you will inculcate in them a feeling of partnership, a spirit of pride, and a desire to co-operate.

I wish to repeat. Success in relationship to your medical practitioners hinges chiefly on the organization of a medical staff (the size will depend on the number of men using your hospital and the number of men in practice in your area). You must make sure it is an active committee and actually taking part in the running of the hospital. Give them responsibility — the responsibility they merit. See that they are kept informed and that they meet regularly. Let them know they are not just figure-heads. They, in turn, appreciating the honour and obligation, will bring to you various problems, as they affect the doctor, and suggest remedies. The snowballing of petty grievances creates an insurmountable bulwark between practitioners and hospital administration.

The proper functioning of this committee is a "must" if you hope to be successful in the administration of your hospital.

Co-operation in Planning

(Concluded from page 44)

candles over the entire work space is installed directly above the main autopsy table. Additional lighting is provided through the medium of an adjustable spotlight located in the ceiling above the head of the table.

The morgue consists of a single, large, four-doored refrigerated unit designed to accommodate up to four wheeled carriers. It is provided with an inconspicuous exit to the outside.

The comfortably furnished combination staff lounge and lecture room, fitted with large picture windows and glass doors opening onto a patio, is enjoyed by all concerned. A splash of colour and a set of wall mirrors mounted above built-in make-up counters are all that were needed to convert an ordinary washroom into the present combination dressing and powder room for the female members of the staff.

The entire unit was constructed at a cost of $110,000—an undertaking which was financed largely from monies generously bequeathed to the Royal Jubilee Hospital by Victoria Jane, daughter of the late J. Keith Wilson, in whose memory this laboratory has been dedicated. A third of the construction cost was met by the British Columbia Hospital Insurance Service.

A man owes it to himself to become successful. After that he owes it to the Income Tax Department.— *E. H. Dreschnack.*

Provincial Notes

(Concluded from page 62)

a 40-acre site, on the Etobicoke river, was purchased. The 200-bed building, to be erected at an estimated cost of $3,000,000, would serve residents of the area from the Humber to the Credit rivers and north from Lake Ontario to Malton. When arrangements are completed a drive for funds will be launched.

* * * *

WINDSOR. The city council recently approved a recommendation of the board of control that a $100,000 grant be made to the Metropolitan Hospital to help furnish the new wing.

Manitoba

PORTAGE LA PRAIRIE. A resolution calling for the construction of a new hospital in Portage la Prairie was passed at a recent meeting of the hospital organization committee. The resolution asks that preliminary plans be prepared for an 80-bed hospital with 21 bassinets. It also asks that additional assistance should be granted by the federal government by reason of the north and south airports.

Saskatchewan

SASKATOON. The Saskatoon City Hospital's board recently adopted a new salary schedule for registered nurses at their hospital, which became effective on November 15. A $30 spread between minimum and maximum salary for each nursing category was adopted, with automatic $5 monthly increases being awarded every six months for three years. As adopted, the new minimum-maximum rate for a general duty nurse is $210-$240 monthly compared with the former schedule of $175 to $205. A head nurse now will receive $225 to $255 compared to $180 to $210 previously. A night superintendent will receive $255 to $285 monthly as compared to $215 to $275. The new salary schedule will increase the nursing staff payroll by $30,000 annually.

Alberta

CARMANGAY. A new addition to the Little Bow Municipal Hospital was opened in November, which provides space for offices. The x-ray department will also be moved into the new addition.

* * * *

LETHBRIDGE. Final approval of plans for the new hospital to be built here, and which will be known as the Lethbridge Municipal Hospital, was given recently when the municipal hospital district board approved three major steps: (1) plans for the $2,800,000, 187-bed hospital to be built on 9th Ave. S. between 17th and 19th streets; (2) a procedure for extending dollar-a-day hospitalization to the rural areas of the hospital district, started at the beginning of this month and (3) estimates for 1953 operations providing for expenditures of $327,730 and revenue of $339,660 with a surplus of $11,930 and a district levy of 5½ mills. Plans were presented to the board by the architect, Fred L. Townley, Vancouver, and were passed after a brief discussion. Work on the hospital is expected to get underway this spring.

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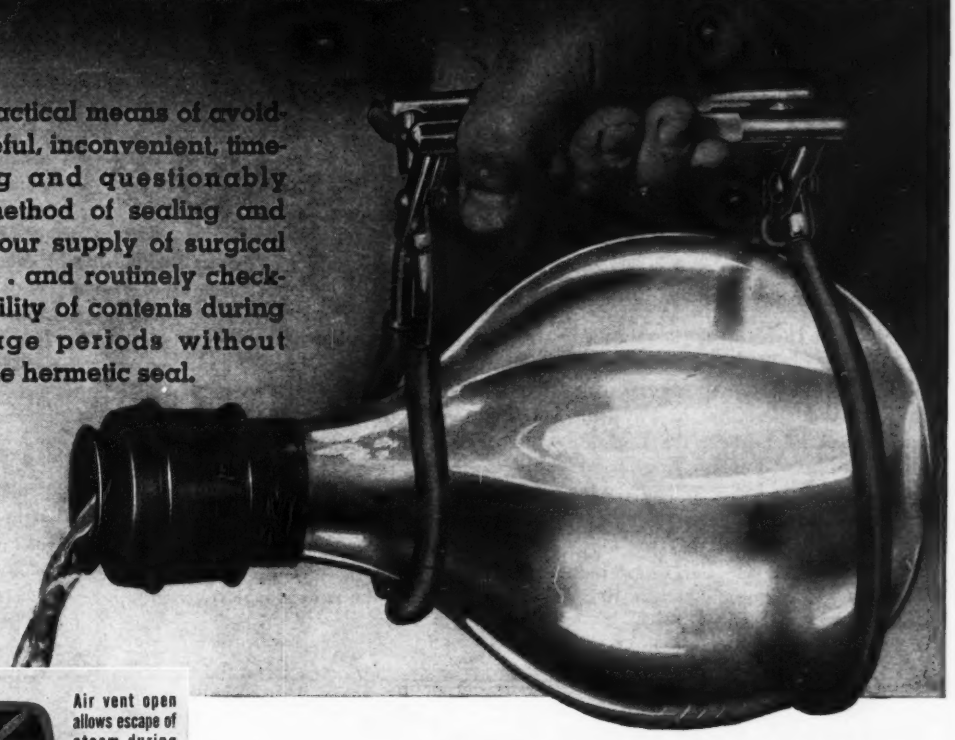
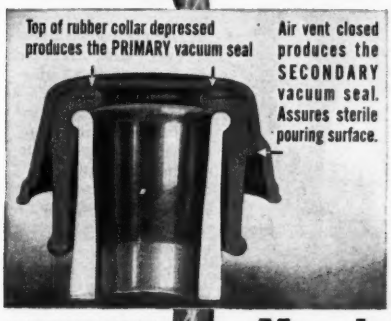
afford a practical means of avoiding a wasteful, inconvenient, time-consuming and questionably scientific method of sealing and handling your supply of surgical solutions . . . and routinely checking the sterility of contents during long storage periods without breaking the hermetic seal.





CONTENTS POUR FROM A STERILE LIP

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Coming Conventions

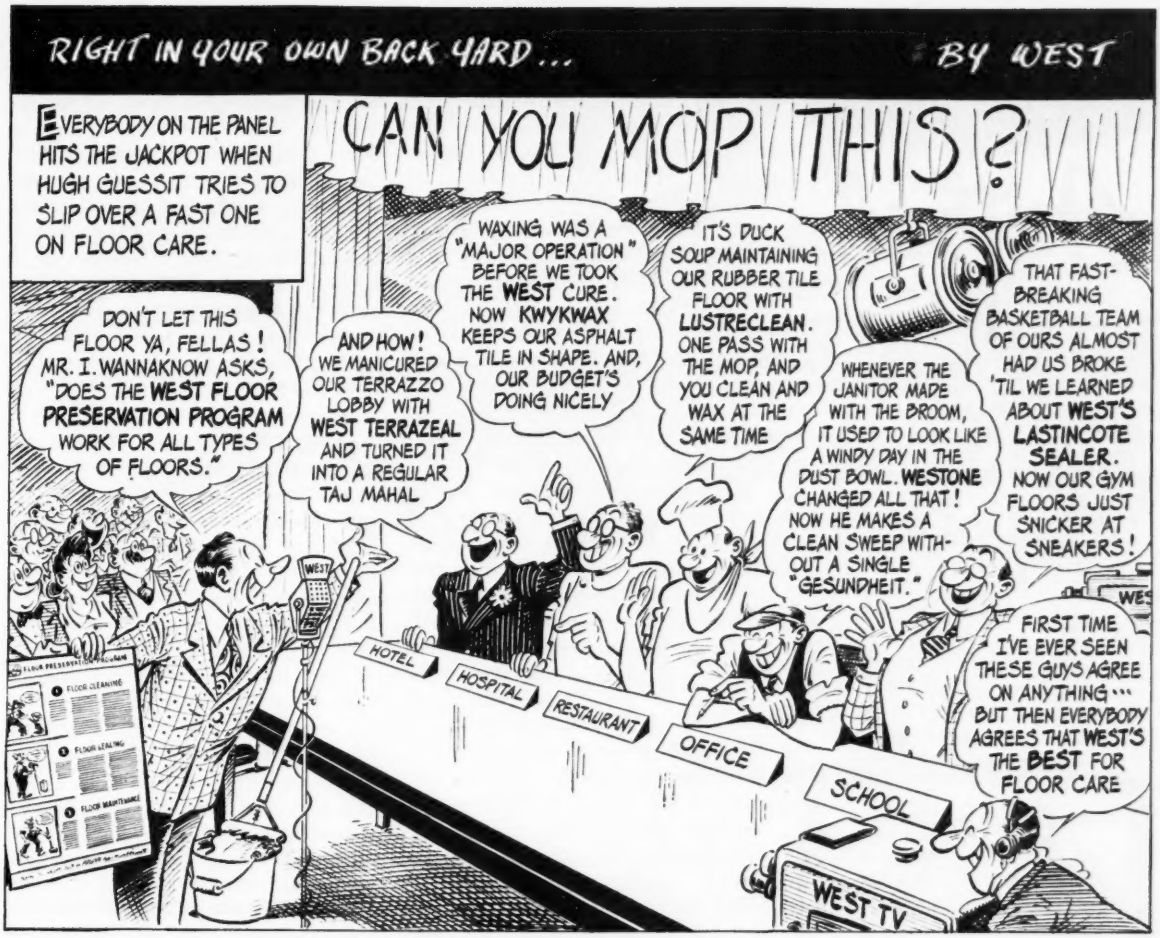
Feb. 5-6—American Hospital Association, Midyear Conference, Drake Hotel, Chicago, Ill.
Feb. 10-13—American Protestant Hospital Association Convention, Palmer House, Chicago, Ill.
May 18-20—Biennial Meeting of the Canadian Hospital Council, Chateau Laurier, Ottawa.
May 25-30—International Hospital Congress, London, Eng.
June 10-12—Annual Meeting of the Maritime Hospital Association, Algonquin Hotel, St. Andrews, N.B.
Sept. 7-12—International Congress of the World Confederation for Physical Therapy, Central Hall, Westminster, London, Eng.
Oct. 19-21—Annual Convention of the Associated Hospitals of Alberta, Macdonald Hotel, Edmonton.
Oct. 26-28—Ontario Hospital Association Convention, Royal York Hotel, Toronto.
Oct. 27-30—Annual Convention of the British Columbia Hospitals' Association, Hotel Vancouver, Vancouver, B.C.

Physical Therapists to Hold First International Congress

The first international congress of the World Confederation for Physical Therapy will be held in the Central Hall, Westminster, London, Eng., from September 7th to September 12th, 1953. Plans for an international organization for physical therapy were begun in 1948 when the Chartered Society of Physiotherapy, Great Britain, invited delegates from 18 physical therapy associations, representing 13 countries, to attend its annual congress in London to discuss international collaboration in physical therapy. At this meeting a provisional committee was set up to investigate the possibilities of organizing an international body. The majority of associations contacted were in favour of such an organization and the provisional committee met in Paris in April 1950 to draft a constitution and suggested that the organization be named the World Confederation for Physical Therapy.

The inaugural meeting of the World Confederation for Physical Therapy took place in Copenhagen, Denmark, on September 8th, 1951. Sixteen countries were officially represented and 140 delegates and observers were present. The recognized physical therapy organizations in the following countries were accepted as founder-members: Australia, Canada, Denmark, Finland, Great Britain, New Zealand, Norway, South Africa, Sweden, United States, and Western Germany. The executive committee of the newly-formed organization accepted the offer of the Chartered Society of Physiotherapy, Great Britain, to organize the first international congress in London in 1953.

Make it a rule of life never to regret and never to look back. Regret is an appalling waste of energy. You can't build on it; it's only good for wallowing in. — *Katherine Mansfield*



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TYPE OF FLOOR	INSTALLED COST* OF 50,000 SQ. FT.
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*Based on reports of reliable flooring contractors in urban areas.

They can be protected almost indefinitely.

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With West's simple, proven FLOOR PRESERVATION PLAN. (1) *Cleaning*—remove all dirt without harming floors (2) *Sealing*—fill the pores. Provide a protective coating (3) *Maintaining*—put on a tough, anti-slip floor wax.

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Alberta Blue Cross

(Concluded from page 51)

the years 1950-51 and 1951-52. In the year 1950-51 the Alberta Blue Cross Plan paid 14,699 claims out of a total membership of 110,508 for an incidence of 133. Last year the incidence of utilization jumped to 140.5 when 16,035 claims were paid, involving 115,763 patient days out of a total membership of 114,099.

The average case cost for the two years under review is also very revealing. In 1950-51 the average cost per hospitalized subscriber was $48.62. The average case cost in the year just closed reached a new high of $61.01, revealing an alarming trend.

Studies of hospital services utilized are being constantly reviewed to anticipate trends of utilization. These studies have proved conclusively that the percentage increase in the cost and utilization of extra services accounts for the largest portion of the higher hospital bill. This is alarming to the operators of the Alberta Blue Cross Plan, since it is difficult to convince a potential patient of the value of the protection offered for an intangible item that only becomes identified with the high cost of hospital service — after use, but more often only at the time the final account is presented.

The Board of Trustees is indebted and grateful to the majority of the hospitals of this association for the high standard of co-operation attained during the past year. The successful operation of any pre-payment plan depends entirely on the active and sincere support of hospitals. No plan can succeed without it.

Yet it is with a certain degree of hesitation that it is now drawn to the attention of this association that there exists a serious delinquency on the part of certain hospitals.

Embarrassment has ofen been caused, both to the subscriber and the Alberta Blue Cross Plan, by the persistence of certain hospitals in submitting accounts for amounts in excess of rates provided for in the uniform rate schedule. It is the feeling of the Alberta Blue Cross Plan, which, as you know, is owned, controlled and operated by this association, that rates adopted by this association should be applied by members of the association in determination of liabilities owing for subscribers covered by this Plan.

It is to be deplored that amounts in excess of the uniform rate structure are charged to the subscriber and in many cases collected. Blue Cross does not want preferential treatment for its members; but it does expect, and in honesty should receive, treatment that can be uniformly applied. As the operators of the association's own Hospital Care Plan, assurances should be forthcoming that acceptance of a uniform rate schedule by this association would be a guarantee by each member of the association that its provisions would be applied uniformly in all hospitals.

It is difficult to forecast what effect duplication of hospital service will have on the future of the Alberta Blue Cross Plan.

Reviewing the past is always easy. Predicting the future is difficult and dangerous — particularly when there is every indication of continuing unstable conditions in the hospital care field.

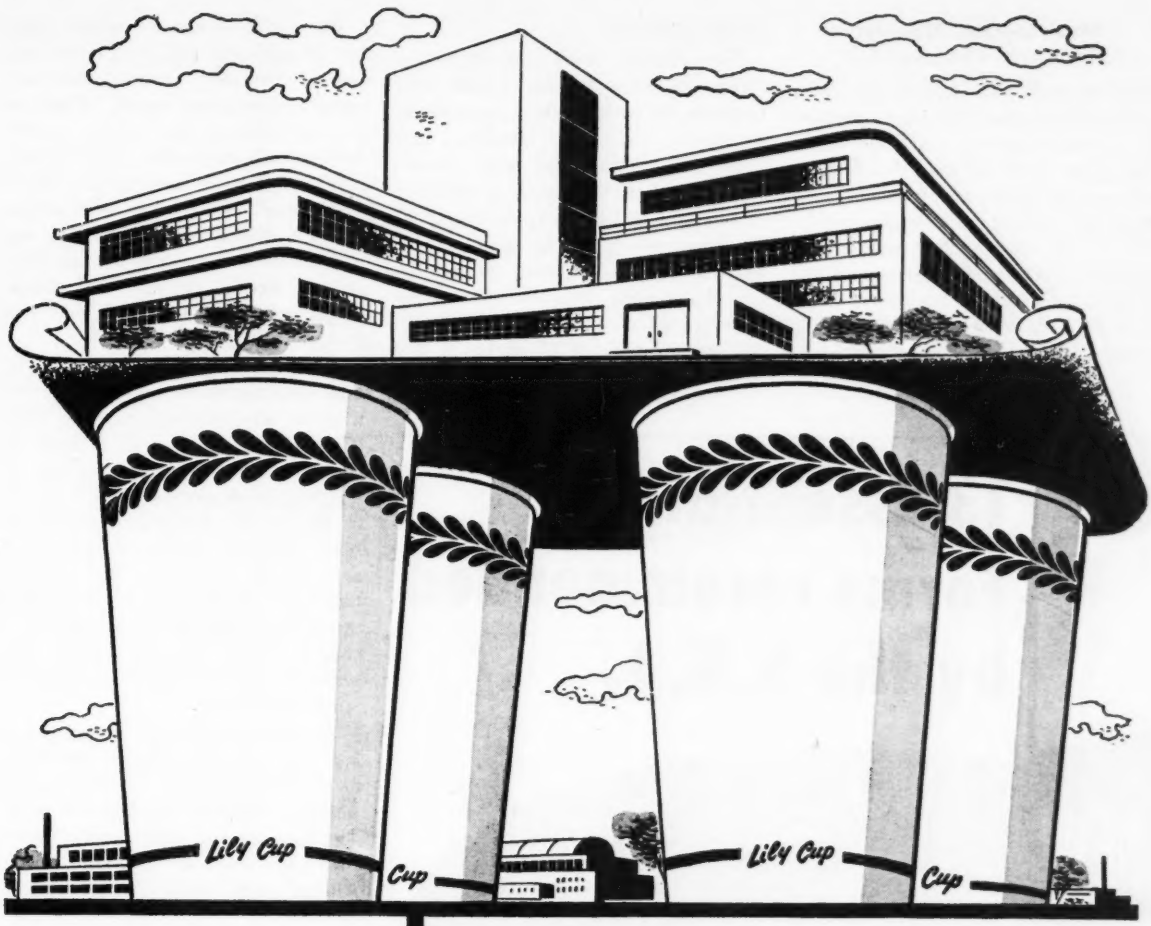
There is, though, some satisfaction to be derived from the knowledge that the trustees of your Blue Cross Plan are constantly aware of changing conditions and have proved equal to the task of facing up to them. When and if conditions warrant, action will be taken to meet fairly the demands of hospital or subscriber.

The Alberta Blue Cross Plan is now privileged to report that, at the invitation of the Honorable Dr. W. W. Cross, Minister of Health, consideration is presently being given for the early submission of several plans designed to supplement the one-dollar-per-day plans. If accepted, these plans will provide against the costs of presently unpaid hospital extras at nominal cost.

Blue Cross is pleased to have had the opportunity of studying this problem. Blue Cross is equipped to do a job in this instance and it is our hope that the plan to be offered will be the most comprehensive that can be purchased anywhere, at any time, for the same low cost.

Blue Cross generally, and your Plan in particular, having proved the ability of doing a job for the subscriber and the hospital, should no longer be regarded with suspicion or treated as a poor relative, but should be welcomed by hospital people.

In Blue Cross you, the hospitals, have created a tool of demonstrable worth—Blue Cross is yours, all yours, to use.



Build tomorrow's hospital on paper

Here are two facts of tremendous importance to architects, hospital superintendents and building committees:

1 — In one year, 500 hospitals changed to complete or partial paper meal service.

2 — One hospital alone saved $300,000 in 7 years through the use of paper service.

Consider then the possibilities for economy when new hospitals are designed for paper service! There would be less space needed for kitchens, pantries; no need for elaborate dishwashing equipment, double sinks, soiled dish counters, endless supplies of soaps, powders, scourers. Far fewer employees would be needed.

Through the use of Lily* Matched Design Hospital Service, many of these economies are in actual practice today. Reports of savings made by various hospitals are available for your inspection.

Write to Lily today for the full story of paper service.

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New Morden Hospital

(Concluded from page 37)

ishes are coloured asphalt tile, with conductive rubber flooring specified for operating rooms and case room. The upper walls are red brick, backed with hollow brick, and insulated with cork, with plaster wall finishes inside. The roof is a low-pitched cottage style to give a domestic character which was thought to be suitable for a small town. It is framed in wood joists insulated with rock wool and covered with fire-resistant shingles.

The ground floor, approximately three feet below finished grade, contains an out-patient clinic, laboratory, dispensary, kitchen, laundry, and boiler room. There are seven maids' rooms and bath with separate entrance at one end and some spare rooms at the other which can be used in connection with a nursing school. A tunnel connects this section to the nurses' residence which has accommodation for about 23 nurses.

The first floor above contains wards for 50 patients and is divided into general treatment wards, maternity wards and long-term wards. There are two operating rooms with a central sterile supply room adajcent and a case room and labour ward at the end of the maternity wing. The usual service rooms, offices, and nurseries are planned to serve wards on this floor and a service elevator and dumb-waiter connect the ground and first floors.

The heating plant consists of one high pressure steam boiler, coal-fired, with an automatic stoker. The steam is reduced to low pressure to serve the convector radiation for heating the hospital and 40-pound steam is carried to the nurses' residence through the tunnel where it is reduced to low pressure for the radiators. The domestic hot water is obtained by steam heat exchangers and all water piping is copper. High pressure steam lines serve the kitchen, laundry, and sterilizing equipment.

A system of exhaust ventilating fans and ducts provide exhaust ventilation to all laboratories, operating rooms, nurseries, kitchen, and laundry rooms. The fans are generally located in the roof space above the first floor ceiling, with all ducts insulated to prevent condensation.

The cost of the building, without furnishings, surgical, kitchen, or laundry equipment, was approximately $248,000. This is just under $5,000 per bed; $10.35 per square foot of floor area, or $1.02 per cubic foot. The nurses' residence and connecting tunnel cost approximately $58,000.

A Worthy Successor

The new Morden District General Hospital is a worthy successor to Freemasons Hospital which will continue to serve the people of the district as a home for the aged and infirm. It will be known as the Tabor Home and in this new capacity will fill another of the great needs of the area.

Preventable Diseases

The cost of preventable diseases imposes a staggering burden on the human race. Every step that can be taken toward lessening this burden will not only diminish suffering and prolong human life, it will also increase productivity and promote prosperity.—*C.-E. A. Winslow*

RADIOGRAPHIC TECHNIQUE

1

Technical Perfection

A medical radiograph must give a true picture. And to be true, the picture must be technically perfect because faults lead to ambiguity and error. Five factors are necessary for technical perfection:

I The subject should be easy to recognize and it should conform to one of the recognized positioning standards.

II Its definition must be good enough to show outlines and structural detail clearly and unmistakably.

III The whole range of opacities in the subject should be represented by a corresponding range of densities in the film.

IV Identification must be correct, easily read, not too obtrusive, neatly placed and permanent.

V The finished film must be clean, free from scratches, spots, and other accidental markings.

There may be times when an intentional or accidental departure from the first three requirements is acceptable, but in general it is safer practice to adhere rigidly to these desiderata.

Malaria Control Successful in Burma

Lashio, railhead for the Burma Road in Burma's Northern Shan States, is fast losing its name as a malaria deathtrap according to reports released in October by the Regional Office of WHO for South-East Asia. Only four months after 355 villages, with a population of 55,000, had their first round of DDT spraying, leading officials and village headmen, interviewed by the WHO reporter, all told the same story of malaria disappearing from areas where previously almost the whole population had been its victims. This testimony is the more striking as September is traditionally a "peak month" for malaria attacks. One headman is reported to have declared that his family could now sleep without nets for the first time in his memory and that flies, cockroaches, and bedbugs had practically vanished from the village.

The project, which already covers an area of 800 square miles situated 100 to 150 miles from the Chinese border, is operated by a team of about 25 Burmese health workers under the leadership of a Burmese malaria expert. They are assisted by seven specialists and technicians from the World Health Organization.

The team's records bear out the evidence of the village people. Detailed surveys show that in villages where previously one-third of the babies became infected with malaria during their first year of life, not one baby born since the village was DDT-sprayed has become infected. This has been scientifically established for a series of typical villages in different parts of the area by microscopic examination of drops of blood taken from hundreds of babies. Similar blood examinations among older people show a general 80 per cent reduction of malaria throughout the area of operation. In one hospital, the number of malaria cases attending for treatment in July and August was only one quarter that for May and June, whereas normally the figures have always shown a steep rise for those months.

Systematic collections of mosquitoes made by the team's insect-collectors in houses throughout the area show that after DDT-spraying has been carried out, the number of mosquitoes caught belonging to malaria-carrying species is less than one-tenth the number found before spraying. In all, the team has captured and classified more than 26,000 mosquitoes. More than half that number have been dissected to see whether or not they were carrying malaria infection.

Intended primarily to serve as a demonstration of control methods based on indoor spraying of DDT and as a practical training ground for malaria workers of various kinds, the project is also reported to be carrying out detailed scientific investigations and experiments. The results of these

experiments are expected to be of great value to the Burmese government in executing a vast five-year plan to give anti-malaria protection to a total population of seven and a half million by 1957. It was learned that the necessary supplies and equipment have been obtained by the government from the technical co-operation administration of the United States government.

Certain of these experiments aim to establish the average length of life of the malaria mosquito and its biting habits. Others aim to determine the least quantities of DDT needed for effective malaria control and to discover whether the whole interior surface of houses needs to be sprayed or only the walls or only up to certain height on the walls.

During this year, the team intends, with continuing assistance from the World Health Organization, to give anti-malaria protection to a total population of 110,000 living in an area of two thousand square miles.

Patients Saved as Fire Destroyed Union Hospital at Eston, Sask.

A fire, believed to have been started by defective wiring in the attic, destroyed most of the 40-bed Union Hospital at Eston, Sask., on December 1st. All patients and staff were safely evacuated to the nearby nurses' residence and much of the equipment was removed from the building. Fire brigades from Kindersley and Eatonia joined with local fire-fighters and hundreds of local citizens to help battle the blaze, which began about 11.30 a.m. and was not brought under control until late afternoon. Loss was estimated at $60,000 on the building and $22,000 on equipment.

Temporary facilities for patients have been set up in the nurses' residence, the Legion Hall, and private homes. Last fall, arrangements were completed with the provincial department of health and towns, villages, and municipalities involved in the operation of the Eston Union Hospital, to build a new $300,000 hospital. It is expected that construction of the new building will be hastened by the loss of the present hospital.

The Eston Union Hospital was the first hospital to be built in Saskatchewan under the Union Hospital Act of 1917. It was opened in 1918. The building, recently destroyed by the fire, was opened in 1931 and the south wing was added a few years later.

Hospital Administrator Wanted

Experienced Administrator required for Regina General Hospital, 800 beds. Applicant should be experienced in hospital administration. Apply by letter giving full particulars, age, marital status, education, experience and salary expected, to: The Chairman, Board of Governors, Regina General Hospital, Regina, Saskatchewan.

Dietitian Wanted

An Assistant Dietitian (qualified) for two hundred twenty-five (225) bed hospital. Apply to Chief Dietitian, Moncton Hospital, Moncton, N.B.

Dietitian Wanted

WANTED—Dietitian for 124-bed General Hospital. Excellent working unit. Apply Superintendent Prince County Hospital, Summerside, P.E.I.

Dietitians Wanted

Two Dietitians are required for 400-bed hospital. Good salary and working conditions. Apply to Elizabeth Bayley, Head Dietitian, Saint John General Hospital, Saint John, N.B.

Dietitian Wanted

Experienced dietitian required. Some experience in administration, therapeutic diets and teaching. Member C.D.A. Forty-hour week with one month holiday after one year. Apply Business Manager, Calgary General Hospital, Calgary, Alberta.

Dietitian Wanted

Dietitian wanted for Charlotte County Hospital. New hospital scheduled to open in the early Spring. Reply stating qualifications, experience and salary expected, to Superintendent, Charlotte County Hospital, St. Stephen, N.B.

FOR SALE

37 Simmons Model 1431 Baby Bassinets
5 Tray trucks — Galvanized Metal — Open Model
54 Bed Side Screens-Brown Finish

All of the above are in good working condition and are available for immediate delivery.

Reasonably priced.

For further details contact Purchasing Office, Toronto East General Hospital, Coxwell Avenue, Toronto.

Dietitian Wanted

Dietitian to head department of 700 bed general hospital. New modern kitchen now being completed. Liberal paid vacation, sick leave and retirement benefits. Salary depends on experience and qualifications. City of 100,000 population with all cultural advantages, situated in southwestern Ontario. Apply giving details of qualifications and experience to the Superintendent, Victoria Hospital, London, Ontario, Canada.

Centralized Lecture Program For Student Nurses in Saskatchewan

Early this year a unique centralized lecture program for nursing students will get underway at Regina College in Regina and at the University of Saskatchewan in Saskatoon. The program is aimed at retaining high standards of nursing instruction by counteracting the shortage of qualified instructors. It will provide four months' instruction in basic science to student nurses enrolled in provincial schools of nursing. After the four-month course, students will be given a short holiday and then begin taking instruction at their own nursing schools. Eight of the province's 10 nursing schools are co-operating in the project. They are: Moose Jaw General and Providence Hospitals, Moose Jaw; Regina General; Holy Family Hospital and Victoria Municipal Hospital, Prince Albert; Saskatoon City Hospital; St. Elizabeth's Hospital, Humboldt; and the Yorkton General Hospital. Students from Regina General, Moose Jaw General, and Yorkton General will attend Regina College while those from the other five hospitals will go to the university.

Each centre will have two registered nurses as tutors, a health counsellor, and a secretary, in addition to university instructors. When the program is underway a travelling instructor will be named to work with the teaching staffs in the various local nursing schools to co-ordinate the whole set-up. Directing the program at Regina will be Lucy Willis, Reg. N., M.A., while Gertrude James, Reg. N., M.A., will hold the same position at the university. Co-ordinator of the whole program will be Hazel Keeler, Reg. N., M.A., of Saskatoon.

The program will be financed by the Kellogg foundation, who will grant $60,000 for the first year of operation; and the provincial government, who will grant $5,000 to the end of the second year and $10,000 after the third year. The Kellogg grant will begin to decrease at the end of the second year. The Saskatchewan Hospital Services Plan underwrites the cost of maintenance and allowances for the students.

Death Rate from Tuberculosis Continues to Fall in Canada

Canada's death rate from tuberculosis has fallen to a new low, according to preliminary figures released by the Dominion Bureau of Statistics. The rate for 1951 is 24.5 compared with 26.2 in 1950, the previous all-time low. Deaths are down in every province but Newfoundland and Saskatchewan and in neither of these is the increase serious. The total number of deaths from tuberculosis in Canada in 1951 was 3,422, of which 1,985 were males and 1,437 were females.

The lowest death rate in 1951 was again in Ontario, with the rate of 12.6. This is the lowest rate ever reported by any province. Alberta comes next with a rate of 15.5; Prince Edward Island, third, with 17.3; Saskatchewan, fourth, with 19.0; Nova Scotia, fifth, with 19.6; Manitoba, sixth, with 20.5; British Columbia, seventh, with 25.1; New Brunswick, eighth, with 26.0; Quebec, ninth, with 38.3; and Newfoundland, tenth, with 70.9.

For the first time in history half of the provinces are able to report death rates under twenty. Three more are in the twenties, Quebec has

dropped to the thirties, and Newfoundland is down to seventy. It is interesting to note that two of the Maritime provinces — Prince Edward Island and Nova Scotia — are in third and fifth place respectively.

Another interesting feature is the fact that the two provinces which show an increase in rates, Saskatchewan and Newfoundland, base these increases on comparatively few deaths. The number of deaths in Saskatchewan in 1950 was 153 compared to 158 in 1951. Five additional deaths in a year are not serious despite the effect they may have on the rate. Newfoundland's rate has gone up from 70.4 in 1950 to 70.9 in 1951 but this represents only nine more deaths — 247 in 1950 as compared with 256 in 1951.

The provisional tuberculosis death rate in the United States is 20.1 per 100,000 of the population. This represents a total of 30,837 deaths in 1951. The 1950 rate in the United States was 22.2, representing 33,557 deaths.—*Canadian Tuberculosis Association "Bulletin", September-October, 1952.*

Assistant Administrator

Saskatoon City Hospital
General Hospital, 350 beds, and 40 bassinets

Applicants should possess a background of responsible administrating experience or formal training in hospital administration, as well as practical experience in hospital operation.

Interested persons should submit details of qualifications, experience, and current salary status, to the General Superintendent, Saskatoon City Hospital, Saskatoon, Sask.

Further information regarding the position will be supplied on request.

Male Nurse Supervisor

Inquiries are Invited

regarding

A New Supervising Possibility

In A

MEDICAL TEACHING HOSPITAL

Located in Ontario

involving

Training and Supervision of Ancillary Personnel as a part of the Nursing Team

Apply to Box 129K,
57 Bloor Street West, Toronto.
The Canadian Hospital.

Give full information concerning qualifications.
Character references required.

. . . Across the Desk

D & G Surgical Film Library

The 14th edition of the Canadian Surgical Film Library catalogue of Davis & Geck, Inc., manufacturers of sutures and surgical specialties, has been released for distribution to surgeons, hospitals, nurses training schools, medical schools, medical societies and other accredited medical and surgical groups. The films are loaned without charge.

The current catalogue of the Surgical Film Library lists some 62 subjects, many of which are Ciné Clinic films from previous Clinical Congresses of The American College of Surgeons.

To meet demands for the films Davis & Geck, Inc., a unit of American Cyanamid Company operating through North American Cyanamid, Ltd., in Toronto, has made 15 to 25 prints of each subject. The Toronto branch of the Surgical Film Library is maintained to ensure adequate distribution within the Dominion.

Requests for the catalogue should be addressed to: Davis & Geck, Surgical Film Library, North American Cyanamid, Ltd., 2004 Royal Bank Building, Toronto 2, Ontario.

* * *

Itemized Receipt Printer

For the first time, an itemized receipt printing cash register, with a built-in adding machine feature, is available at a low price. Manufactured by The National Cash Register Company of Canada Limited, Toronto, this machine mechanically adds the individual prices in a multiple item sale, adds the amount of tax, if any, and prints the total on a receipt. The itemized receipt is the patient's "take-home" proof of what was spent for each item purchased, and the hospital's greatest assurance that correct prices are recorded. The receipt also shows the name of the hospital, date, identification of the clerk and departments. The register is especially suitable for cafeterias, tuck shops, outpatient and other departments where cash transactions are customary.

The adding machine feature can be used for any adding job, at any time, without disturbing the locked-in cash register total.

The Class 21 can be operated both electrically and manually. It registers any amount from 1¢ to $999.99 at one time.

* * *

New Berkel Plant

Mr. Gerard Elshout, President of Berkel Products Co., Lmited, 2199 Bloor Street, West, Toronto, has announced the opening of their new Plant No. 2, located at 4252 Dundas Street, West, Toronto.

This new building provides a spacious area for the factory and shipping departments with an attractive office located on the main floor. The sales and general offices of Berkel Products Company will continue to be conducted from the present location at 2199 Bloor Street, West.

In addition to their world famous Slicing Machines, Berkel now offers a complete line of food processing equipment including Meat Choppers, Power Meat Cutters, Coffee Mills, Refrigerated Counters and Scales.

* * *

Canadian Sales Manager of Dixie Cup

The Dixie Cup Company announces the appointment of Austin G. Malone as Canadian Sales Manager with headquarters in Brampton, Ont. Mr. Malone is replacing Mr. Ralph Isaac who has been transferred to the company's home office in Easton, Pa.

A native of Canada, born and raised in Alexandria, Ont., Mr. Malone has been with Dixie Cup since 1934 in a variety of assignments. Most recently he was Manager of Dixie Cup's West Central Region.

* * *

Propper Introduces New Sterilizer Control

Propper Manufacturing Co., Inc., well-known manufacturer of hospital, surgical and laboratory supplies is introducing a new paper sterilizer

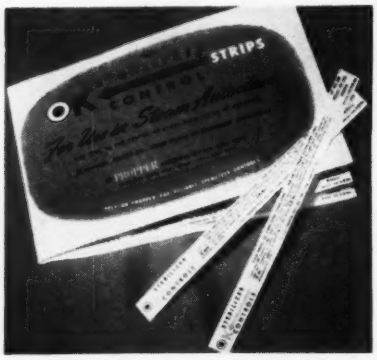
(Concluded on page 96)

Across the Desk

(Concluded from page 94)

control for use in autoclaves.

This new indicator is called the OK Sterilizer Control Strip. The indicator section is designed to provide unusual clarity and thus eliminate any possible confusion in reading.



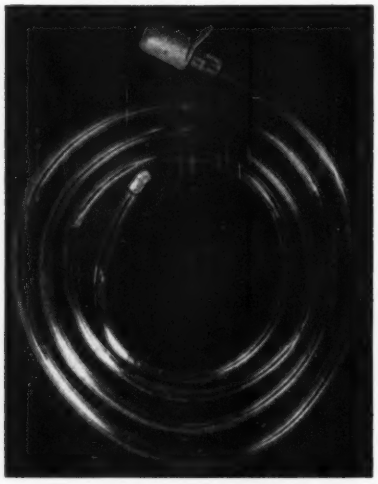
OK Sterilizer Strips are packed in convenient "tear-out" books of 250 indicator strips each. Samples for test and examination may be obtained by writing the manufacturer at 10-34 44th Drive, Long Island City, N.Y.

* * * *

Disposable Bedside Drainage Tube

C. R. Bard, Inc., Summit, N.J., announce a disposable plastic drainage tube for bedside use. It is packaged sterile, in individual boxes, with necessary connector ready for immediate use.

The tube is five feet long with a large lumen to assure ample drainage



and has an adapter affixed to one end for instant attachment to an indwelling catheter.

The sterile packaged Bardic Disposable Plastic Drainage Tube provides an economy that has instant appeal to all hospitals, as it is ready for immediate use with adapter already affixed.

* * * *

Hospitals Protected Against Power Failure

How hospital patients and staff members are protected against electric power failures is shown in a new two-color folder just issued by D. W. Onan & Sons Inc., Minneapolis, Minn.

Models of Onan Standby Electric Plants for every hospital need, from electric lights for operating rooms and exits to power for elevators and heating systems, are described and illustrated. Units range from 1,000 to 35,000-watt sizes in both air-cooled and water-cooled gasoline-engine driven models; full Diesel Electric Plants are listed in sizes from 12,500 watts to 55,000 watts. Automatic A.C. line transfer controls, designed to take over the load within seconds after commercial power is interrupted, are described.

In addition to listing more than seventy modern hospitals now equipped with Onan Standby Power, the folder pictures a dozen of the more prominent hospitals and shows their electric plant installations.

The folder is available upon request.

* * * *

Westeel Products Limited Officers

At the November 19th Meeting of the Board of Directors of Westeel Products Limited, the following officers were elected: G. W. Hutchins — Chairman of the Board; E. S. Sargeant — President; P. F. Fowle — Executive Vice-President. All have been Directors for many years.

G. W. Hutchins

Norman S. Robson

It is wth deep regret that we report the death on November 17th of Mr. Norman S. Robson who, until a year ago, was the manager of the hospital department of Wilmot Castle Company, Rochester, N.Y. His death occurred following a long illness. He retired a year ago.

Mr. Frank Rice, who has been associated with their hospital sterilizer and hospital light division for many years, is now manager of the hospital division.

* * * *

E. S. Sargeant

P. F. Fowle

Index of Advertisers

JANUARY, 1953

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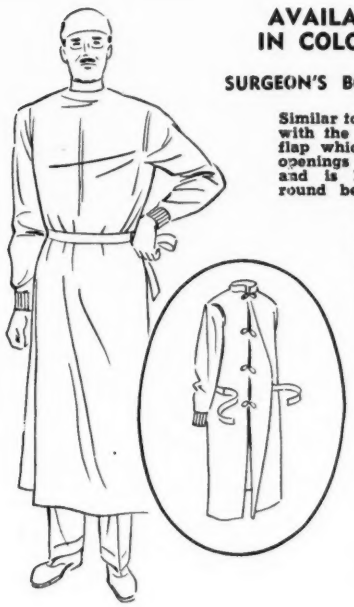
Medical garments of top quality and value



AVAILABLE IN COLOUR!

SURGEON'S BONE GOWN

Similar to our style 431 with the addition of a flap which covers the openings at the back and is held by all-round belt. This feature makes gowns more sterile. Can be made in coloured, bleached or unbleached materials.

SURGEON'S OPERATING SUITS

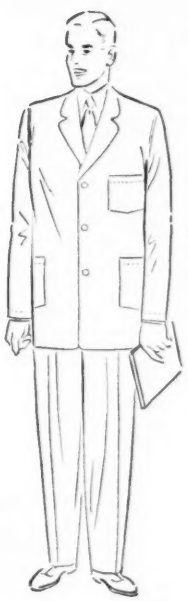
SURGEON'S BONE GOWNS

HOUSE DOCTOR'S COATS

Made from finest available materials

Designed for extra long wear.

All Corbett-Cowley Operating Room Apparel and Equipment whether in colour or otherwise—is made from only the finest materials available. Each pattern is cut full with plenty of room for extra wear. All garments are expertly designed and skilfully produced to stand up under the most rigorous use.



HOUSE DOCTOR'S COAT

Style 103. Made of bleached drill, this coat is neat and serviceable. It has notched lapel collar, three pockets, detachable buttons and hemmed sleeves.

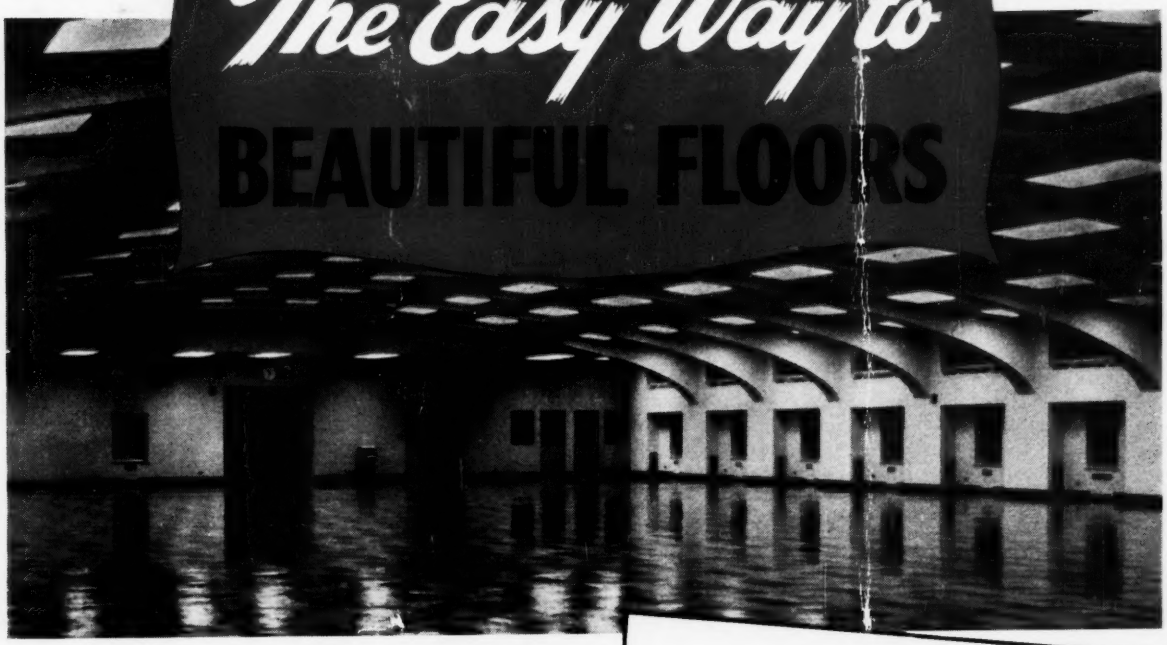
SURGEON'S OPERATING SUIT

Style 356. This one-piece garment (no buttons required) is in great demand for surgeon's work. The adjustable tie-tape belt and one-piece feature alone commend its use. Made from best quality bleached suiting. Stocked in even sizes 34-44. These garments also available in any colour—made to order.

CORBETT-COWLEY
Limited

2738 Dundas St. W., Toronto 9 424 St. Helene St., Montreal 1.

The Easy Way to BEAUTIFUL FLOORS



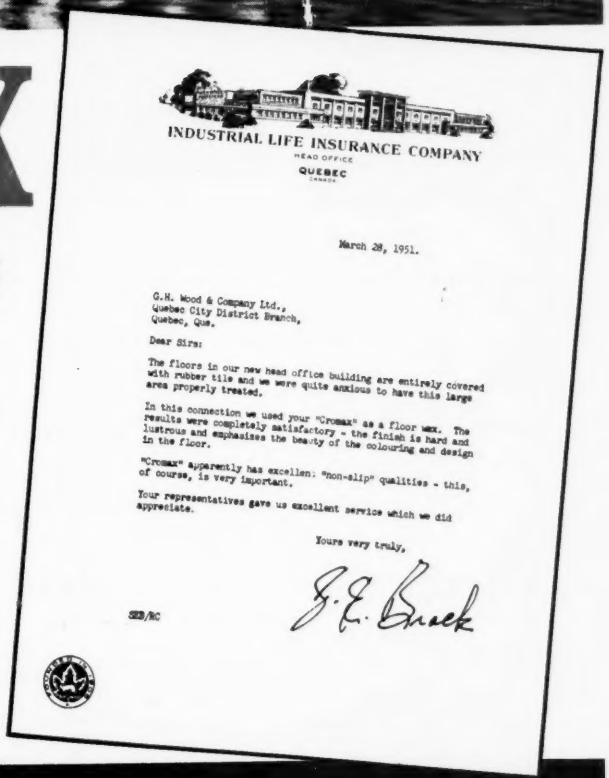
CROMAX

Liquid Floor Wax

Give your floors a gleaming protective finish that is hard, durable and non-slip, with CROMAX Liquid Floor Wax. Your beautiful floors will stay beautiful.

CROMAX is a water emulsion wax made from pure Carnauba Wax. It is non-flammable . . . economical . . . and easy to use. Contains no solvents or fillers of any kind. CROMAX is especially prepared for the treatment of Rubber, Linoleum and Mastic Tile floors.

CROMAX is excellent for use in offices . . . schools . . . hospitals . . . hotels . . . apartments . . . and wherever heavy traffic occurs.



INDUSTRIAL LIFE INSURANCE COMPANY
HEAD OFFICE
QUEBEC
CANADA

March 28, 1951.

G.H. Wood & Company Ltd.,
Quebec City District Branch,
Quebec, Que.

Dear Sirs:

The floors in our new head office building are entirely covered with rubber tile and we were quite anxious to have this large area properly treated.

In this connection we used your "Cromax" as a floor wax. The results were completely satisfactory - the finish is hard and lustrous and emphasizes the beauty of the colouring and design in the floor.

"Cromax" apparently has excellent "non-slip" qualities - this, of course, is very important.

Your representatives gave us excellent service which we did appreciate.

Yours very truly,

J. E. Brack

GEB/RC

TORONTO
MONTREAL
VANCOUVER

Wood's SANITATION FOR THE NATION

BRANCHES THROUGHOUT CANADA

G. H. WOOD & COMPANY LIMITED